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ADEQUATE MATERNITY SERVICE

One of the frequent questions presenting itself over the last two years to boards of directors of public health nursing agencies and in some instances to the staffs of health departments as well, has been: "Shall we start or continue a home delivery service?" Naturally, in the light of recent studies,* the opportunity to prevent many maternal deaths by providing skilled medical and nursing service at home at time of delivery offers a challenge to every public health nursing service genuinely interested in community health and a preventive program. It will be remembered also that at the Biennial Convention in Washington, Dr. Kosmak made a special plea to boards of directors of visiting nurse associations to provide nursing care to every patient in her home at time of delivery, pointing out that the New York study showed that properly conducted home confinements for normal cases were as safe apparently as hospital deliveries—at least "greatly increased hospitalization of parturient women in the past two decades has not brought a corresponding reduction in the puerperal morbidity and mortality notwithstanding the advances in medical knowledge and the improvement in hospital facilities . . . we might have to revise our ideas about the apparent disadvantages of home confinements, at least in certain population groups."** Dr. Rothert of the U. S. Children's Bureau also points out that "The best prenatal care is of no avail unless it is followed by good delivery care and good postpartum care . . . Good delivery care is indispensable."***

Through the widespread interest aroused in the maternal mortality rate of the United States by public health agencies, notably the Maternity Center Association of New York, through Mother's Day propaganda, through studies and community surveys, we are all brought sternly to the issue—Is home care at time of delivery more important now than certain other branches of our service? Should funds be reallocated or specially solicited to install this nursing service? Is it the responsibility of the local public health nursing agency to offer this service or to see that this service is available?

Many considerations immediately

*N. Y. Academy of Medicine, 1934; U. S. Children's Bureau, 1934; Philadelphia Survey of Maternal Mortality, 1933; Cleveland Maternal Mortality Study, 1933.

**See June PUBLIC HEALTH NURSING, p. 294.

***See August PUBLIC HEALTH NURSING, p. 409.

arise in our minds. First and foremost is of course the strictly local one—Has our community already such a service and is it adequate? If we have not, do we need it; statistically are there enough home deliveries unattended by a nurse to warrant the initiation—or continuation—of this relatively expensive service? Even if statistics show a need, are our medical authorities—official and private—in favor of using such a service, are the patients interested, what number of cases are being served by midwives, or would prefer midwives under any conditions? Incidentally, of course, what supervision is being given to midwives? How does the Council of Social Agencies feel toward such a service, especially the health committee? Would it be possible to develop an adequate home delivery service as an out-patient service in a hospital? What is the relationship of the professional nursing registry? If the private public health nursing agency seems the logical one to provide the service, how shall such a service be financed: by a re-distribution of emphasis in the whole program, by discontinuing some less needed service; by appealing for special funds; by carrying only a fully paid service; by requesting a larger appropriation from the community chest; or how? What monetary return, if any, can be expected for the care of those on relief rolls either from city or special relief funds? Again, how does the local medical society feel about the whole question of fee schedule for nursing care at delivery?

All these and many more problems confront the agency about to start or question the continuance of a home delivery service. May we suggest that it is a *community* problem? It involves the health officer, the medical profession, the hospitals, the out-patient services and dispensaries, the professional nursing registry, the public health nursing group, and—vitally—the expectant mother. A thorough knowledge of the community situation should be gained,* its shortcomings analyzed and plans for meeting the needs made coöperatively by all the groups aforementioned. Since this type of service is usually carried on by the private public health nursing agency, it is entirely appropriate for this agency to consult its medical advisory committee and local health officer, to offer to join in a survey of the situation and to form the nucleus of a committee to start community-wide effort if the preliminary survey—statistical and social—shows a definite need. As always national agencies, including the new N.O.P.H.N. Committee on Maternity and Child Care, stand ready to advise or help local groups in all phases of this particularly knotty problem facing us in 1935.

*See Appraisal of Maternity Program, PUBLIC HEALTH NURSING, October, 1932, and the suggested survey of maternity resources issued in May, 1934, by the Maternity Center Association.

SUCH A HEALTHY ACORN

Who could ever dream that when the tiny acorn, "Little Red," was planted in the Adirondacks fifty years ago it would result in so many big, flourishing sanatoria? For "Little Red" was the first building used in the United States for the modern treatment of tuberculosis. Edward Livingston Trudeau was the far-sighted physician who secured from his friends $400 to build, on a pine-clad hillside, the cheap little one-room cottage. It accommodated two patients. And it was due to his vision that from such a humble beginning we now have in the United States 659 modernly equipped institutions that can care for 86,917 patients.

That healthy acorn has seen many changes in our attitude toward tuberculosis as well as in its treatment, and since the 1934 Christmas seal depicts

the "Little Red," in commemoration of its fiftieth anniversary, let's reminisce a bit.

Fifty years ago is not a long time, but so much has been learned of tuberculosis during this comparatively short period that it is difficult for some of us to imagine how gruesomely overpowering consumption, or the *consuming* disease, was. Tuberculosis took more lives than any other sickness, and to have a cough, a hectic flush, and fever meant certain death. The only treatment given then was to keep the patient within doors in a stuffy, sunless room while family and friends sorrowfully awaited the inevitable approach of the Grim Reaper. The picture of Elizabeth Barret Browning in her elaborate, lacy peignoir, reclining on a couch in the heavily draped and darkened room, surrounded by dust-collecting ornaments and knick-knacks of Victorian popularity, is typical of the tuberculosis patient of that time. Fortunately, she was rescued by Robert Browning and grew happy and healthy in Italy's warm sunshine. But she was an exception—most patients succumbed at an early age.

Trudeau himself had nursed his younger brother who had tuberculosis. He, too, had watched those last days of fatalistic suffering, both certain that death would come. He had even slept in the same bed with him, because it was not known that tuberculosis was infectious. Everybody thought it was inherited. The brother died and Trudeau finished his medical course. He received the position of House Physician in a New York hospital and married. A baby daughter arrived and all seemed to be contributing toward a happy, prosperous future. Suddenly the blow fell. He found that the upper two-thirds of his left lung was involved with active tuberculosis.

What he suffered at hearing that verdict is what thousands of others have suffered when told they have tuberculosis. It is described so simply and so tragically in his *Autobiography* that even those who have never had the same sentence pronounced, feel, through these words, a great sympathy for all tuberculosis patients:

"I stood on Dr. Janeway's stoop, I felt stunned. It seemed to me the world had suddenly grown dark. The sun was shining, it is true, and the street was filled with the rush and noise of traffic, but to me the world had lost every vestige of brightness. I had consumption—that most fatal of diseases! Had I not seen it in all its horrors in my brother's case? It meant death and I had never thought of death before! Was I ready to die? How could I tell my wife, whom I had just left in unconscious happiness with the little baby in our new home? And my rose-colored dreams of achievement and professional success in New York! They were all shattered now, and in their place only exile and the inevitable end remained!"

How Trudeau went to Paul Smith's in the Adirondacks to die and how, even after the cold and hardships of a northern winter, his health improved, is known to all. What we need to recall, however, at this Christmas season when we use the tuberculosis seals on letters and packages is how Trudeau's dream came true. All over the country today are sanatoria where Trudeau's treatment of rest, fresh air, and nourishing food is being practiced. Each year sees hundreds of men and women return to healthy, normal lives. Research, too, is being carried on in many laboratories, work which was instigated by Trudeau in his first laboratory for tuberculosis research in this country.

In using the seals, the funds from which have made possible so much of the machinery for combating tuberculosis, we are paying honor to Trudeau. We are showing, too, our appreciation for all he did toward changing the feelings of despair and death, experienced by every patient fifty years ago, into a hopeful, self-confident belief that health may now be re-won—that tuberculosis is curable.

Impressions of Mora

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Mora in the Afternoon Sunlight

ON the old Santa Fe Trail about a century ago, it was customary for the voyagers, traders, trappers, settlers and soldiers of fortune to join their forces for the hazardous journey which ended at the ancient La Fonda Hotel at Santa Fe. By coöperative vigilance under the leadership of a caravan captain elected at the beginning of the journey, the pioneers with their mules, sheep and cattle were able safely to make the journey across the plains, desert and mountains in spite of the passive hostility of nature and the active hostility of Indians and marauding white men.

In November 1933, the art gallery of the picturesque modern La Fonda in Santa Fe, was the scene of meeting of a group of people united in a common purpose, namely the amelioration of the health conditions under which the people of New Mexico live.

In this group were representatives of the New Mexico Bureau of Public Health, the United States Bureau of Indian Affairs, and indirectly the United States Public Health Service. All these governmental agencies had a stake in the undertaking under discussion. Representatives of the American Public Health Association, the National Tuberculosis Association and the American Social Hygiene Association were present as consultants for the purpose of making national experience available for group guidance and inspiration. The officers of the New Mexico Tuberculosis Association and the New Mexico Social Hygiene Association and a representative of the New Mexico Chapters of the American Red Cross were present as sponsors of the undertaking, which was sufficiently comprehensive and promising to arouse national as well as local interest.

The project which called forth this display of unity and enthusiasm was a state-wide survey of those health problems of New Mexico which are regarded as having preëminent importance today, *viz.*, the problems of tuberculosis, syphilis and malnutrition. It was foreseen also that in the process of investigating

these three major health hazards much would be learned regarding rural sanitation, typhoid fever, malta fever, and dental conditions, and early in the discussion it was indicated that the National Society for the Prevention of Blindness should be invited to study the causes and prevalence of impaired vision and blindness in New Mexico.

Coöperation typified the provisions for financing the survey. The New Mexico Tuberculosis Association voted to devote to this project a large part of its receipts from the 1933 seal sale, and even before the annual sale, as a token of earnestness, this Association employed a public health nurse to make the preliminary arrangements for a special syphilis study in Mora County. The New Mexico Social Hygiene Association emptied its treasury in the interests of the survey. The State Bureau of Public Health made laboratory and other services available and agreed to "match" funds from sources other than the state treasury. The several federal agencies contributed services, while the four national health associations, including the National Society for the Prevention of Blindness which soon joined the project, supplied both personnel and field expenses to a considerable amount.

THE PEOPLE AND THEIR LAND

It helps one to understand the Spanish American to think of him as a peasant. Held by the vigorous beauty of their mountains and mesas, taught resignation by the padres whose cross their ancestors had followed from old Mexico over the long hard trails through El Paso del Norte, they have been content with the simple gifts of nature—food, children and sunshine. Shelter they made for themselves out of the same soil which gave them sustenance, and their adobe homes fit as naturally into the landscape as a tree or a boulder.

Since the stirring pioneer days Mora has changed only superficially. There are filling stations, a few telephones, and daily postal service. But step off of the main street into the hotel and the years turn backward. There is no running water in the hotel, no bath, no toilet and no telephone. Across the placita and down the stone walk at the back of the garden is a privy with a liberal supply of newspapers and five-cent journals. Small stoves supply heat for the rooms of the hotel, as indeed for most of the homes of Mora except those which are provided with the beautiful Spanish fireplaces.

If Mora, a town of 1,000 souls has changed but little in a century, even less has time and invention modified the tiny hamlets lying along the primitive roads which wander uncertainly from the highway up the narrow valleys. Not quite impassable to motor traffic, it is rarely that they are used by automobiles, for the local inhabitants have no cars and they find it more convenient and quicker to travel the mountain trails on foot than to follow the roads in their heavy farm wagons. The hamlets consisting of a few adobe houses, a tiny Roman Catholic church, a school, a general store and post office straggle picturesquely along streams which serve at once as water supplies and drainage ditches. Open privies, very popular with flies, are placed with reference to human convenience and without regard to the terrain or its drainage, with the result that after a rain the bright little streams rush busily down the valley gathering pollution as they go. The inhabitants do not make a practice of boiling water before using it, nor do they screen their houses against flies.

Tillable soil is not plentiful, but in the many years since this region was settled it has been parcelled out so that most families have sufficient to produce the beans, chili, pumpkins and corn required for existence. These constitute the main article of diet. With natural art, the Spanish-American farmer decorates his home with nature's bounties, the deep red chili, and yellow and blue corn. Each family has a cow or goat, the milk being used mainly for cheese and as a diluent for coffee. Amazingly little milk is drunk by children and it is unusual for a family to boil milk before consuming it.

Up the rough dirt road from Mora to

one of these hamlets an old Ford car bearing a public health nurse, a doctor and a Spanish lad of twenty, called Gonzolo, made its way in the bright morning sunshine of November, 1933. There was snow on the ground and crystals of ice on the tall weeds and on the bare branches of the silvery trees. The sun

Clinic in the Schoolhouse

sprinkled the landscape with vibrant iridescence. The Sangre de Cristo mountains were violet blue in the distance. The padres who named them must have seen them in the evening light from Santa Fe, in order to find in that view a suggestion for the name, "Blood of Christ."

Gonzolo was driving the car for only an expert in these roads could find his way among the rocks and across the streams, and Gonzolo is such an expert. He is half Indian, half Spanish, and was employed as handy man, interpreter and driver for the health survey team which with their equipment he was then conducting to a tiny school house in one of the many hamlets called by such beautiful names as Carmen, Buena Vista, Guadalapita. Virtually only Spanish-Americans live in these valleys. Of the 1,674 individuals examined by the health survey team mentioned above, all but 18 were native born Spanish-Americans bearing Spanish names and speaking Spanish. Naturally and properly they resent being called Mexican. Practically all of them have been born in the United States.

AT THE CLINIC

A crowd greeted the car as it drew up to the school house. Men, women, and children gathered about the door to see the doctor and the nurse arrive. The school was a one-room adobe building with rough board floor, narrow windows and dilapidated desks. The teacher, a young man of about thirty, was unshaven and not quite clean. The nurse, who had been to each village previously to prepare for the diagnostic clinic, introduced the doctor, and the teacher made a little speech in very courteous but incorrect English.

Quickly the desks were arranged for the clinic equipment. The teacher was set to registering the people and soon the clinic was in full operation, with Gonzolo acting as interpreter and washer of syringes. The crowd had grown surprisingly and all wanted to crowd about the doctor and nurse as they took blood specimens from the arms of all who were willing, in order to determine the prevalence of syphilis, Malta fever and, (in the town of Mora) of typhoid fever. A holiday had been declared in the village

and the whole population had come to the diagnostic clinic. A troupe of young men standing at one of the windows commanding a view of the clinic activities played on guitars and sang Spanish songs. Suddenly there was a commotion and an old woman burst through the crowd shouting something in Spanish. "What's up, Gonzolo?" asked the doctor. "She wants to know which is the doctor from New York," said Gonzolo, and then, after a pause, he added, "I hope that she thinks that *I am* the doctor from New York."

During 16 working days, 21 clinics were held and 1,674 individuals were tested. All who desired it were granted an interview with the doctor and the obviously ill or infirm were asked to wait for examination at the conclusion of the clinic. It was not unusual for a man or woman to come to the nurse and ask, "Must I have a test for bad blood?" "Of course not, do just as you wish," the nurse would reply. "All right, then, I will have it," was the invariable decision.

To encourage children to submit to the blood test, a liberal supply of sweets was provided and each child who allowed a specimen to be taken was given a piece of candy. So successful was this procedure that a careful watch had to be kept to prevent would-be repeaters from effecting the exchange a second time.

Unaccustomed as they were to the sight of blood in a syringe, a few men and women, and fewer children, fainted, and such is the power of suggestion that when one individual suffered an attack of syncope, there were sure to be others. Great excitement was caused by several individuals who, under the nervous strain of unaccustomed medical attention, inadvertently had fits. The exclamations and prayers of the deeply-impressed bystanders added to the commotion caused by the characteristic expressions of epileptic seizures. The clinics were evidently a great social success, and a good time was had by all, even by the "fainters" who suddenly found themselves the center of much sympathetic attention.

One morning the crowd in the diagnostic clinic was so large that the nurse and the doctor needed help more than usual. The doctor looked over the crowd and saw a girl of 17 who appeared clean and capable. "Would you like to help us?" asked the doctor. "Yes, sir," said the girl. "What shall I do, Doctor?" "I would like to have you roll up the sleeve of each person, put on this thing (indicating a tourniquet) and clean the arm with this alcohol. I will show you how." "Oh, I know how already, Doctor," replied the girl, "I have been watching you." And she proceeded during the rest of the clinic to demonstrate dexterity and intelligence of very unusual order. The next day upon our arrival at a neighboring hamlet, to our surprise, we found the girl awaiting us anxious to help again. For several days she followed us riding her pony many miles over the mountain trails. "You would make a splendid nurse," said the doctor one day, "could you go to a hospital and study nursing?" "I would like to," she replied, "but I have no money and my mother and father would not let me. They do not know that I am helping you but think that I am visiting my aunt in Buena Vista."

About 10,000 people live in Mora County, a territory approximately twice the area of Rhode Island. The mountainous western portion of the county is more thickly populated than the eastern mesa region. In Mora County large families are fashionable, or at least numerous pregnancies are customary although due to foetal and neonatal deaths many women who have had 10 or 12 pregnancies have but two or three living children. But sickness and death are viewed with considerable stoicism,—what Providence does is good, think the Spanish father and mother of Mora. Pain, illness and infirmities are borne with resignation and prayer, for medical care is not available to the vast majority of families. It may be many miles to the doctor,—at this writing there is but one in the whole western part of the county. Usually there is no money to pay for medicine, even if, as is often the case, the doctor is willing to render his services gratuitously. Because of these

economic factors, and due to the fatalistic attitude of the people, more than half of the illnesses ending fatally progress to their termination without the alleviating care of a physician.

WHAT THE CLINIC REVEALED

It is of interest to consider the obvious medical conditions found among those examined clinically, bearing in mind the fact that this examination was necessarily superficial due to lack of time and because the only instruments available were a stethoscope and a pocket flashlight.

Among the most frequent conditions met with were impetigo contagiosa and scabies. Whole families were encountered with these conditions, in part a reflection of the unhygienic conditions under which they live. Chronic constipation was a frequent complaint, especially among women. Chronic gallbladder disease was diagnosed in several cases. A few cases believed to have chronic duodenal ulcer were discovered. In one region, a valley north of Mora, were found a surprising number of large goiters, traceable, it is believed, to the water supply.

A considerable number of cases of tuberculosis were found, including two boys with kyphosis, three tuberculous joints, one tuberculous rib, and two cases in which a clinical diagnosis of pulmonary tuberculosis was made. In three of these cases of tuberculosis, syphilis was established as a complicating factor.

Malnutrition was apparent in a great many of the children seen. A consideration of the diet of these children,—the preponderance of beans, chili, and pumpkins, the lack of fresh fruit, the failure to use milk even when the family possess a cow or goat, accounts for a considerable part of the dietary deficiencies.

Malta, or undulant, fever, is a specific infectious disease which has been reported with increasing frequency in the United States since its manifestations and methods for its recognition have become better known to the medical profession.

Tests for evidence of Malta fever were made on blood specimens from 1,621 inhabitants of Mora County in the course of this study, with the result that a total of 73 specimens, or 4.5 per cent of all, were positive. However, among the positives only one, or .06 per cent of the total specimens, gave a reaction in dilutions as high as 1 in 80. It is believed that positive tests in dilutions of less than 1 to 80 are not significant evidence of infection. Twenty of the individuals giving a positive agglutination test for Malta fever were examined clinically and questioned with the following results: none presented any symptoms or signs of Malta fever; none had any illness resembling Malta fever within the past two years; all used unboiled milk of cows or goats.

It is possible to draw only tentative conclusions from the findings briefly mentioned above. If Malta fever exists in this group, it is apparently of subclinical variety. The individuals who gave feeble positive reactions may have developed an active immunity, or small amounts of antibodies from ingested milk may have caused agglutination in low dilutions. In any case, it does not appear from this feature of our study that Malta fever is a serious medical or public health problem in Mora County. Nevertheless, all of the individuals examined were advised always to boil milk before using it, and to wash their hands carefully after caring for animals.

TYPHOID FEVER

Typhoid fever, on the other hand, is recognized as one of the most serious problems of Mora County, and indeed of the state. During 1933 there was a small outbreak of typhoid in the town of Mora and several cases occurred elsewhere in the county. The water supply of the town is drawn from wells, many of which are unprotected. The house fly is a great nuisance especially during the warm season. As mentioned, there is no pasteurization of milk, nor is boiling of this article of diet customary. A part of the population has had antityphoid vaccination, but due to lack of funds this prophylactic measure has

been curtailed during the past two years, so that with the lapse of time and diminution of the effectiveness of previous vaccination, a larger and larger number of people have become susceptible to this disease.

Since about 90 per cent of vaccinated individuals give a positive Widal test, specimens for the Widal test were taken in the diagnostic clinic in the town of Mora only from unvaccinated individuals, with the object of discovering carriers and cases of "walking typhoid". In Mora a total of 295 specimens was taken and of the total specimens tested, 34 or 11.5 per cent gave a positive Widal reaction. When we consider that these individuals were apparently healthy, that typhoid carriers may give a very weak Widal reaction, and that only unvaccinated individuals were tested, it seems probable that these 34 cases are at least potentially carriers of typhoid fever. The most frequent focus of infection in typhoid carriers is in the gall-bladder and the bile duct, the organism escaping in the fæces. Therefore, the next step in finding the carriers of typhoid in Mora is to examine the fæces of those who have positive Widal tests. As rapidly as possible this is being done, not, however, overlooking the need for better sanitation of the water and milk supply, and the necessity for better personal and home hygiene.

SYPHILIS

An impression exists in the southwest that syphilis is very prevalent among the Spanish-Americans. Indeed, physicians have told the writer that they believe it reaches proportions equal to that of syphilis among the American Negroes. There were in New Mexico certain indications of a high syphilis prevalence rate such as, for example, a high still-birth rate, but as will appear, the syphilis prevalence rate in Mora County is not very different from that which we believe to exist generally in the United States. The best statistical opinion obtainable places the general prevalence of syphilis for all ages, races and classes in the United States at about 5 per cent. Serological tests of individuals in Mora County gave clear positive results in 5.8 per cent of the bloods of 1,646 men, women and children over 6 years of age. Of the total group, children from 6 to 11 were 2.5 per cent syphilitic, males 12 and over 6.9 per cent, and females 5.7 per cent.

One of the hopeful aspects of the problem among the Spanish-Americans is their frank and rational attitude toward syphilis. Surprisingly little stigma is attached to "sangre impura", or bad blood. No embarrassment on the part of infected individuals was observed when they were questioned about the disease and the sources of infection. Prophylactic measures are practically unknown amongst them. Sanitary arrangements being what they are—no running water in homes, no modern toilet facilities,—it is doubtful whether the prophylactic potentialities of soap and water used after exposure have been tried out by many Mora inhabitants.

In Mora County very little indeed is done for the prevention of congenital syphilis through the treatment of syphilis in pregnant women. Prenatal medical care is not usually obtainable by women living in isolated villages and even in the more accessible communities poverty prevents most women from consulting a doctor until the onset of labor. Hence, serological tests of pregnant women, the only practicable way of discovering 95 per cent of cases of syphilis in them, are not made.

It is recognized that syphilis in pregnancy ends in still-birth in 25 per cent of untreated cases, and that of live-born infants of syphilitic women, 20 per cent die in early infancy. Consequently since so many syphilitic pregnancies end in stillbirth or neonatal deaths, one does not expect to find a high syphilis rate in young children. After the age of puberty the syphilis rate among children tends to rise due to acquired infection. In view of these facts, children of the youngest age group were not expected to show a very high percentage of syphilis. In the Mora County study only one child under six years of age was given the serological tests.

To what extent may the findings in

Mora County be considered as representative of the Spanish-American population of New Mexico as a whole? It is believed that 1,646 persons who had blood tests for syphilis were representative of the general Spanish-American population of this county. They were unselected and included an adequate number of males and females at all ages except children below six years. But the geographical location and the poor transportation facilities of Mora County, the absence of any large center of population may well lead to the supposition that the population of this county is more protected and less exposed to infecton than the Spanish-American population of a more urban county. Everything considered, it seems probable that the prevalence of syphilis in rural parts of New Mexico is approximately the same as that discovered in Mora County. If 60 per cent of the population of New Mexico is Spanish-American this would mean that of the 250,000 Spanish-Americans about 14,500 have syphilis.*

The histories and clinical manifestations of syphilis in infected individuals reveal an unusual situation, namely, an almost complete lack of knowledge regarding this disease and its treatment, and virtually total absence of available medical care for the prevention of the late crippling and fatal manifestations of syphilis. The problem of medical care, then, is the most urgent one both for the preservation of the lives and health of infected individuals and for the prevention of the spread of syphilis, for by modern treatment syphilis in a majority of cases can be quickly rendered non-infectious.

To every one who knows him the Spanish-American and his family present numerous problems of education, sanitation of homes and villages, medical care, and public health. Among neglected people the Spanish-American is in some ways the most neglected. In New Mexico the Indian under the care and protection of the Federal government is better clothed, fed and doctored than the Spanish-American. Yet in the hamlets of Mora County are many people of great natural charm and ability. Has not the Spanish-American something precious and unique to offer his country, equal at least to that of the Indian, the Negro or the newly arrived immigrant upon whom so much of the money of philanthropists has been spent? In planning for constructive work with this part of the state's population the New Mexico Bureau of Public Health and the associated voluntary agencies wisely sought first to learn the essential facts upon which a scientific program may be founded. The findings suggest that the problems are so large that help from outside the state will be needed if these descendants of the first white Americans are to be rescued from tuberculosis and syphilis, ignorance and poverty which now prevent their advancement.

*In this connection it is of interest to compare the results of the survey in Mora County with serological studies in rural and village populations in other states. Of the male workers in a rural coal-mining community in West Virginia, 2,372 Americans were 5.1 per cent and 778 foreign-born were 6.4 per cent positive. Physical examinations of several thousand men working in lead and zinc mines in Oklahoma and Kansas showed that 8 per cent were syphilitic. On the Cherokee Reservation, North Carolina, 1,080 Indians serologically tested were 6 per cent positive. On the Klamath Reservation, Oregon, 5.9 per cent of the Indian inhabitants were presumably syphilitic. In a serological survey 30,090 individuals in five rural Negro southern population groups in Mississippi, Alabama, Georgia, North Carolina, and Tennessee, 8.7 per cent of all children under 15 years of age were found to be syphilitic (largely congenital); 26.2 per cent of females over 15 years were positive; and 24.5 per cent of males. In Mora County it will be remembered that the prevalence figure for the entire group was 5.8 per cent, and that, of these, children were 2.5 per cent positive, males over 12 years of age 6.9 per cent, and females 5.7 per cent positive.

Parent Education Program in a Health Department

By ANNIE GABRIEL, R.N.*

SINCE its very beginning the work of the public health nurse has been largely parent education—teaching the parent how to care for the child's physical needs and something of what to expect in the way of normal growth and development. Inevitably, in discussing the nutritional and health needs of the child, the nurse would be confronted with problems whose implications were psychological rather than physical, such as "Johnny just will not eat green vegetables", or "Mary dislikes all cereals." Another very common problem that the nurse finds when making home visits is that of enuresis. But the hospital schools and the public health nursing courses of fifteen years ago did not offer information on the psychological aspect of these problems.

A nurse working alone in a rural county far from any clinical facilities felt somewhat inadequate for her job as parental advisor and many times after a home visit the nurse knew that she had left the mother feeling rather hopeless about her most pressing problem in the care and training of her children. So, it seemed that in order to make public health nursing more effective it was necessary to obtain further education in the psychological care of the child. Because of this felt need the author spent one year studying child psychology and parent education in three of the leading schools giving courses in this field.

It seems fitting, then, that the institution of a professional program of parent education in Florida should have taken place in the State Board of Health. Especially so since the inspiration for the service was the result of the agitation and insistence of a school nurse who had discovered that the community in which she served recognized the need for information regarding the mental hygiene of child care. At that time the physician in charge of the Bureau of Child Hygiene had previously had experience with parent education teachers in another state. So it was not a difficult matter to obtain the assistance of the Director of this Bureau in seeking a parent education teacher. The big problem was that of finding a nurse who could qualify as a parent education teacher. The Joint Vocational Service was appealed to and in almost no time a nurse with the necessary qualifications was located. The Florida State Board of Health started the work as an experimental project with some misgivings as to the demand for the service.

BEGINNING THE SERVICE

The service was begun in January 1931. At first the nurse divided her time between regular field work in public health nursing and parent education classes. The work at that time was limited to twelve counties along the east coast of Florida as these counties constituted her district. Eight classes were organized by local Parent-Teacher Associations in the territory between Daytona Beach and Palm Beach. The classes met twice a month; between classes the nurse carried on a regular program of public health nursing.

When these local Parent-Teacher Associations reported at the meeting of their State Convention in April, that they had had the services of a parent education teacher who had been trained for this work under the Parent Educa-

*Miss Gabriel, until June, 1934, was working with the Florida State Board of Health and her full-time services were offered as a loan to the Florida Congress of Parents and Teachers to carry on the program described here. She is at present completing work for her Ph.D. degree at the University of Iowa.

tion chairman of the National Congress, other groups were stimulated to request the service and within a few weeks enough such requests had been received to keep the instructor busy during the coming school year. In September 1934 the nurse-instructor was loaned by the State Board of Health for full-time service to the Florida Congress of Parents and Teachers. The Florida Congress was well organized and prepared to use the service.

The classes were then organized on a county-wide basis, the Parent-Teacher Associations doing the organization work and making up the schedule. The first series was held in Orange County (Orlando) with twenty-two groups meeting once a week for six weeks. It was soon discovered that the teaching schedule was too heavy for the instructor, so other localities were notified that the maximum number of classes per week would be fifteen. This number was later reduced to twelve.

Although the Parent-Teacher Associations sponsored the service, it was understood from the first that the classes were open to all adults whether or not they were members of a P-T.A., and to men as well as women. Occasionally classes were organized by federated or home demonstration clubs. In many counties classes were held at night so more of the men could attend. Where a sufficient number of colored people were interested, classes were organized for them. In Tampa where there are large numbers of Cubans who do not understand English, two groups were organized and instruction was given through an interpreter. The interest and attendance of both groups were high. Some of the most interested groups were in small towns and rural areas. In isolated places like the Florida Keys where there was only one group, the classes met daily for one week. As a stimulus to regular attendance, those who attended as many as four times were given a certificate by the State Board of Health.

Each meeting of the study group consisted of a short talk by the instructor, followed by questions and round-table discussion. Almost always fifteen minutes or even longer was consumed in the discussions. Parents were able to make many helpful suggestions to one another. Criticisms of parental treatment of child behavior problems were frequently sought and graciously received. The goal in the mind of the instructor was not primarily to change the child's undesirable behavior but to help the parent attain an objective viewpoint on problem situations; to get over to the parent the fact that there is a reason for all behavior problems, and that the best method of correcting these problems is to discover and remedy the causes back of them. In doing this it was found best at times to avoid giving a direct answer to the question, but instead to lead the parent to think through the situation and to find his or her own solution. Occasionally a parent would suggest that she knew she was a cause of undesirable behavior in the child. In contrast to these mothers were those who did not detect even serious behavior problems in their children. These were almost always those whose educational background was poor. The most eager and interested mothers were the college graduates in home economics, ex-teachers, and others who had studied problems of child care and homemaking.

Group meetings were held usually in the school building and as many as possible met at the hour immediately after the close of the school day, so the teachers could attend. The teachers were almost universally interested and very helpful in the discussion.

DISCUSSION TOPICS

The topics for discussion were grouped under the headings of Family Relationships, Disciplinary Problems, Character Education, Problems of the School Child, Problems of the Adolescent Child, and Sex Education. The last named was always a popular topic; some groups asked that a whole series of six lessons be given to a discussion of Sex Education and related problems. At first the men members of the class were invited to be absent the day the

lesson topic was Sex Education, but one time a local Boy Scout leader came anyway, as he said that he needed some help. After that the men were always invited to attend. While the discussion was less free in the mixed group, it did proceed and some mothers, particularly, were helped to overcome their inhibitions.

Several times the leader suggested a list of topics dealing with the health and physical care of the child but no group was ever interested in this series, although it is significant that in assembling the questions asked in the groups the second largest list dealt with health problems, the largest list being the one on Sex Education. The other popular topics were those dealing with the problems of the elementary school child and of the adolescent; the least popular those dealing with the preschool child. Yet the greatest benefits accrue from preventing behavior difficulties from developing during the early years. When the child enters school much of his behavior is "set" and the problems of correction and cure are more difficult to handle than those of prevention.

HOME VISITING SERVICE

Because the time that could be given to discussion was limited and many of the mothers were desirous of more detailed information in regard to their problems, a new service was instituted in September 1932, that of making home visits to mothers. These personal interviews were held only on invitation from the parents, never because some neighbor hinted that a mother needed advice. This has proved to be a fruitful service. Many times new light has come to a mother from her own discussion of the difficulty. Then, too, the parents could talk much more freely at home as they did not feel they were airing family difficulties. The service was very time-consuming; it was found that almost never could a mother tell the instructor all she wished about her children in less than two hours, and sometimes the interview consumed six hours. Not infrequently the father would be at home when the instructor called, and often he would be less emotional than the mother and for that reason had a more objective viewpoint. In other cases where his coöperation was the thing most needed, the visitor could impress him with the fact that he shared the responsibility in the care and training of the children.

In few instances the reason for inviting the instructor to the home was for advice in regard to divorce proceedings, which of course, is outside the field of the parent education teacher. It might be mentioned, however, that in these homes the child behavior problems were found to be more serious and more complicated.

TEACHING HIGH SCHOOL GIRLS

Another service was that of teaching the child care unit in the second year of the home economics course in a few high schools. The girls were always intensely interested and the two weeks reserved for this unit were always too short. The topics discussed included the physical care of the infant and young child, growth and development, habit formation, emotional control in the young child, which was always followed by a discussion of the problems of emotional control in ourselves, and the final topic choosing a life mate. This last named topic always resulted in a lot of frank discussion. Frequently there would be one or two engaged girls in the class who were keen to have information regarding marriage and parenthood. Invariably the question of birth control would be introduced by one of the students.

The girls would ask many kinds of questions about child behavior and in every class there would be one or two who would have some care of a child or two. These girls would report with delight how they had tried out some of the methods suggested in class. Sometimes the girls would send mothers of preschool children to the parents' class, while they cared for the babies.

Another question that nearly always came up was that of interesting the parents in further education for themselves. And they were not always fault-

finding in their attitude, some were really interested in the parents' welfare. Some girls said that their mothers never went anywhere except to church and they realized that their lives were narrow and uninteresting, yet the solicitation of their daughters failed to interest them in P.-T. A. or other clubs.

In one school all of the two hundred girls enrolled in the senior high school were released from their classes for the first period in the morning for two weeks, so that they could attend a series of lectures on child care and mental hygiene. A very efficient dean of girls had built up a fine spirit in the students and their response was quite unusual. At the close of the series the girls were asked to give a frank, unsigned written opinion of the lectures and all but eleven thought them more than worth while.

In the three years of the service, all districts of the state have been reached and about one-third (22 out of 67) counties have had classes. About ten thousand individuals have been enrolled in the classes one or more times. The enrollment and attendance depended largely on the interest and enthusiasm of the local study group chairman and the preliminary publicity given to the project. In one village of about two hundred people, the enrollment reached thirty. Here the chairman was a former visiting teacher. The average attendance in the larger towns was usually between 25 and 30, but a few classes had an average attendance of 75. In the small town and rural areas, each school had a separate class, since so few facilities for transportation were available. In the larger town three or four schools would combine into one class. At first we tried meeting in different schools but it was found that the attendance was better when all the meetings for a given locality were held in the same school.

Publicity was given to the classes through notices carried home by the children, announcement in churches and other meeting places, and through the newspapers. The newspapers in most places were very coöperative.

UNMET NEEDS

Several needs that have arisen in connection with the service remain unmet. Perhaps the greatest need at present is that of organizing and conducting several institutes for the training of lay leaders for local study groups. No one or two professional parent education teachers can possibly teach all of the child care classes in a state as large as Florida. One questions whether it is necessary to have professional parent education leaders do all of the teaching. Nearly every school system has one or two teachers, who, with careful instruction can take charge of study groups of parents. Also in most communities exteachers and other college graduates can be found who would be capable of teaching classes. Care should be exercised, however, in selecting the right person, as not all who think they are authorities have the personal qualifications or sufficient preliminary training to lead a group.

Another problem that has not been satisfactorily solved is that of division of time between the larger towns and the purely rural areas. The attendance in the thinly populated sections is always small, yet in these communities there is a dearth of local leaders and many times no outside agency contacts to give inspiration or even desire for improvement. The state-supported institutions do owe some service to these rather isolated areas. On the other hand three or four times as many people can be served in the same amount of time in the larger towns.

Another real need is for five or six nursery schools located in different areas of the state to demonstrate the value of scientific study and observation of normal preschool children. In a state catering to winter tourists as Florida does, a well equipped and efficiently managed nursery school in each of the tourist centers would be an added attraction to winter visitors as well as fill a need for all-year residents.

Finally some way should be found of interesting those who should profit most from a program of parent education, namely the mothers of preschool chil-

dren and the underprivileged parents. Of the ten thousand persons reached, practically none have been underprivileged white parents. The colored and Cuban groups are the only ones of lower economic status who have been interested. Of course, it is impossible to educate persons who do not seek information, but not all of the underprivileged fall in this category. Other states have found ways of interesting and helping the mothers whose educational background is meager and some organization in Florida should be working at this problem.

Parent education is the infant in the education family and it needs careful nurture in the course of its development, for it undoubtedly will grow. As it develops many more workers will be needed, a large percentage of whom might well come from the ranks of public health nursing since the well being of the child, physical and mental, forms such a large part of the work of the public health nurse.

An Advisory Committee for Official Agencies*

By MARY D. CARPENTER

Municipal Nurses' Board, Department of Public Welfare, City of St. Louis, Mo.

THE functions and activities of the Municipal Nurses' Board of St. Louis may be more clearly understood if a brief history of its origin is sketched.

More than fifty years ago, in response to a request from a woman physician, a group of men and women in St. Louis investigated the facilities for caring for the patients in the City Hospital. Conditions were found to be very primitive, and the so-called care so inadequate that a committee was formed, funds were raised by private subscription, and a school of nursing was founded. A graduate nurse from the New York Hospital was brought to St. Louis—Emma Louise Warr—who undertook the training of the very few young women who were willing to enroll as student nurses. The school was a success. As they completed their training, the graduates were placed upon the city pay-roll and an excellent nursing staff was built up. The City Hospital became a teaching center for nurses and doctors, and gained a prestige which it has never lost. The committee continued to conduct the School of Nursing until 1915, when the city received a new charter. The school was then taken over as a city institution, for which an annual appropriation was made, but its conduct was left in the hands of a lay committee, named the Municipal Nurses' Board.

The Board functions through an ordinance which provides that there shall be seven members, three of whom must be women. The Hospital Commissioner appoints them for seven-year terms, one member's term lapsing each year. The Board must be non-partisan, must serve without compensation, and its members are selected with a view to representing the whole community. The Board has authority to conduct the two municipal schools of nursing—a school for the training of Negro nurses having been established in 1921—and this must be done in such a manner that the best possible nursing service is furnished to the patients in the Municipal Hospitals. Appointments to the graduate nursing staffs of all the Municipal Hospitals and to the staff of the Municipal Visiting Nurses are made upon recommendation of the Board, subject to the approval of the Hospital Commissioner and of the

*Presented at the N.O.P.H.N. Round Table for Board Members (staff of ten nurses or more), Biennial Convention, Washington, D. C., April 23, 1934.

Commissioner of Health. Staff nurses and executives have the right, under the ordinance, to appeal to the Board for a hearing on any question related to the schools of nursing or to the nursing service.

In 1915, through the efforts of the newly-appointed Nurses' Board, a city appropriation for a Municipal Health Center under the direction of the Commissioner of Health was granted. The center was opened with one physician in charge of the clinic sessions and three graduate nurses to assist in the health program and to do follow-up home visiting. In 1919 the need for expansion of the work of this one center was met by coöperation with the American Red Cross and the Tuberculosis Society; and during 1919 and 1920, six additional centers were opened, and additional graduate nurses were employed. The annual budget was met by contributions from private individuals, several centers being named by their donors, and from the Tuberculosis Society and from the Red Cross, who assisted in supplying nurses. The city also increased its appropriation.

As the need still increased, a survey was made of the city, with assistance from Dr. Haven Emerson, and the centers, which are all in rented quarters, were located at strategic points, to serve the population with the greatest economy. The centers proved their value so conclusively that they were finally taken over entirely by the city, an annual appropriation was made for the maintenance of the program, and as the need was indicated, other centers were opened until there were ten.

Our best physicians coöperate generously in the clinic sessions, of which more than 3,000 were held last year. Child hygiene, child guidance, prenatal care, tuberculosis control, and dental care for children are the types of service rendered, with seventy-five staff nurses and supervisors assisting, and one medical social service worker giving full time. More than 52,000 home visits were made last year by the nurses, the follow-up work necessary in the control of acute communicable disease under the Commissioner of Health being included in this program. No bedside nursing is performed by the Municipal Visiting Nurses, since the work of both the clinic physicians and of the nurses is confined to a health program. Representation in the Community Council of Social Agencies keeps our nurses in close touch with allied services throughout the city, and duplication of effort is avoided in every possible way. It is the policy of our agency to serve only those who are unable to pay for medical and nursing care and advice.

Under an educational supervisor, the students from the two Municipal Schools of Nursing and from the Washington University Public Health Nursing Course receive two months' training in public health field practice in the health centers. New staff nurses receive special instruction, and all the staff nurses are encouraged to continue public health training in the night courses offered by our two universities. The number of Negro public health nurses on our staff is in the ratio of the Negro percentage of population. The staff is proud of its one hundred per cent membership in the N.O.P.H.N.

Some of our health centers have had valuable assistance from volunteers for several years. This assistance is very much appreciated by our staff nurses and it is hoped that it may be increased as volunteers are trained. The volunteer program as now organized under the Community Council of Social Agencies, with a Central Registration Bureau and a Placement Secretary, offers carefully planned courses of study under professional guidance, closely supervised field work and careful checking-up of qualifications. The movement is significant on account of the possibilities of expansion of social work with volunteer assistance and without increase in the budget; the value of intelligent interpretation of professional programs to the public through the volunteers; the development of future board members of discernment from the ranks of the volunteers; and the growth of a richer life for many people to whom volunteer service has made its appeal.

Maternal Milk Collection

By HAZEL M. KEENE

Assistant to General Director, The Directory for Mothers' Milk, Inc., Boston, Mass.

TWENTY-FOUR years ago Dr. Fritz B. Talbot spent the greater part of three days traveling by electric cars and on foot in an unsuccessful effort to locate a wet nurse for a very sick infant. The experience of those three days led to the establishment of the original Directory for Wet Nurses in Boston, Massachusetts.

Dr. Talbot first persuaded a friend to back the experiment and then rented a house large enough to accommodate six mothers and their babies. Maternity hospitals coöperated by sending friendless mothers who welcomed the shelter thus given them and their little ones. An announcement of the establishment of the Directory was sent to every physician in Massachusetts and to many in other large cities of New England.

From the first the Directory filled an urgent need, but as the project grew this method of handling the problem was given up because of the overhead expense and the inability of the limited number of women to produce sufficient milk to supply the needs of both private patients and hospitals. In 1926, through the Community Health Association, a public health nurse was secured to visit the mothers in their homes and collect the supply. This plan proved so successful that after one year the original idea of maintaining a residence was given up, the house sold, and a room secured in a professional building as an office distributing center, and the name changed to The Directory for Mothers' Milk, Inc. Collections that first year—5,451 quarts over the 1926 total—proved the soundness of the plan, and it was necessary to seek larger quarters. A laboratory and administrative office were secured in the same building and the staff increased to three graduate nurses, a clerical assistant and a part time worker. Miss Cornelia Macpherson, the newly appointed General Director, in presenting her first annual report that year, illustrated by a pin map the daily collection route and the possibilities in the area as yet untouched. The sales figures plainly showed two problems: when orders decreased suddenly, hospitals and institutions were offered this surplus milk free, but the balance was thrown away. The even greater problem was—what could be done when our orders increased suddenly beyond the daily collections?

Meanwhile quarters were again found too small to handle the increased business and in 1930 we moved to our present location at the Boston Lying-In Hospital building. We maintain our independence and identity, paying rent to the Hospital for our quarters. The laboratory (approximately 17 x 22) and two small offices, comprise our suite. We pay $1,200.00 per year rental for the space which includes steam, gas, electricity and chopped ice for packing our orders.

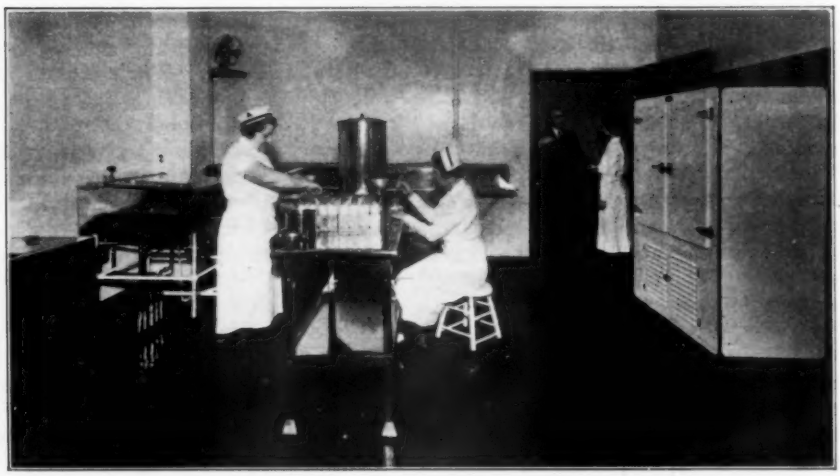
The location of the hospital in the Harvard Medical Center made it possible to establish a teaching program for medical students at Harvard, Boston University and Tufts College. The Boston Lying-In is an affiliated school and all student nurses and postgraduates are reached as we have a regular teaching assignment. The students from the Home Economics and Five Year Nursing courses at Simmons College come as separate class groups, as do also the dietiticians from Boston hospitals.

We feel the information given the medical students and nurses will prove of inestimable value when they meet feeding problems in their own practice.

TECHNIQUE OF COLLECTION

Our mothers are referred through obstetricians, the maternity hospitals

and community health centers. We have our own physician examine the mothers, and a Wassermann test is taken. When the first contact with the mother is made in the home, the nurse takes a personal history, listing past and present pregnancies, health, and a record is started of the baby's weight. As most of the mothers are already in attendance at a weighing clinic, we are assisted greatly in our check on the babies' progress. In this way we guard against the mother's depriving her own baby in order to sell the supply to us. So far we have had no trouble with our mothers. Emphasis is always placed on the fact that we want only the surplus milk after each feeding of the baby. Seventy visits were made to mothers this past year who, for various reasons, could not be accepted.



The Laboratory, Directory for Mothers' Milk

The mother is instructed in the technique of expressing the milk and the importance of following the routine required. Waterpower breast pumps are used. A separate tray, kept covered, must have on it a jar of boric acid solution, absorbent cotton, paper napkins, nail brush and orange wood stick. We also require a covered saucepan for use in boiling the pump parts and funnel and this pan must be used for nothing else. Sterilizing of the pump parts and funnel is stressed, covering the hair, scrubbing the hands, and washing the breast first with soap and water and wiping off with boric solution and tucking paper napkins around the clothing, is required routine.

After putting the milk into the sterile bottle, (which the nurse leaves when she collects the milk daily), the mother must chill it and place it immediately on ice. Each mother is provided with a number on a ring, which she slips over the neck of each bottle for identification.

PAYMENT FOR MILK

The mothers are paid 7 cents an ounce. We pay by check once a month. Some mothers receive $80.00 for their month's supply, although the average amount is $35.00. The mothers sell their supply to us for about nine months, and often return during successive periods of lactation.

We have between thirty and forty mothers on our list and as soon as one discontinues we take on a new mother. It takes time, of course, to work up the supply. Two nurses cover the collection area and the cars used by our nurses are equipped with ice boxes for carrying the supply from the home to the laboratory.

The entire supply collected is strained, pooled, bottled in amounts corresponding to each needed order, then pasteurized.

A specimen of the pool is taken once a week for laboratory test, and a specimen, without the knowledge of the mother, is taken on the individual mother's supply at regular intervals to insure safety against dilution and quality. The milk, after being pasteurized, is labelled with the baby's name, and packed in ice, in small boxes (8 bottle size) for delivery. The surplus or emergency supply is placed in an electric refrigerator with a temperature of 40 degrees F.

CHARGES AND RANGE OF SERVICE

Prices fluctuate greatly according to the means of the family. A personal request from the physician and a social investigation guide us in determining the rate of pay. Private cases are charged from one cent to thirty cents an ounce. Cash is received daily in the majority of cases. Private cases in hospitals pay weekly. Hospitals are charged fifteen cents an ounce, which is the cost price to us, and they are billed once a month. We do not maintain a delivery system of our own. Local messenger service is used when needed. Out of town shipments go by express and baggage. We are the only organization in New England, and we cover the area with the same service as in Boston, with twenty-four hour telephone connection to assist the physicians. We also let it be known through the New England medical journal that we are on twenty-four hour service and ship to all parts of New England.

Breast milk need no longer be considered either as an unaccustomed luxury or as an unobtainable commodity. No baby need ever suffer for lack of mother's milk. In addition to the milk sold on the sliding scale of prices, 7,439½ ounces have been given free so far this year; to babies at home 5,148 ounces; to babies in hospitals 2,291½ ounces. Our improved laboratory facilities, made possible by gifts from members of the Board, have enabled us to continue under more ideal conditions, and to give more efficient service.

We are now approaching our quarter century mark. Every ounce of mother's milk supplied throughout these years went to help some infant fighting against odds for life. Every mother who sold her surplus milk to us had the joy of knowing that she was helping some other mother's baby, the benefit of increased knowledge of hygiene and care of her own, which brought better conditions of health and cleanliness into her home, and in addition the financial assistance which brought many an added comfort for her own family.

An annual appeal for funds is sent out by the Directory for Mothers' Milk and the amount secured from this appeal has covered the yearly deficit.*

How the problem of controlling the supply and demand was met in Boston will be told in an article "Preservation of Human Milk," in the January issue of this magazine.**

*Boston does not have a Community Chest.—*The Editors.*

**Previous articles on the collection of mothers' milk as it has been carried on in New York, Detroit, Hartford, and Grand Rapids, were published in this magazine in 1927, 1928, and 1933. See index for these years.

The Cost of a Visit

New Method of Computing Chargeable Costs

It will be remembered that in 1932 when the N.O.P.H.N. prepared "Principles and Practices in Public Health Nursing Including Cost Analysis"* the recommendation for arriving at the cost of the visit involved careful and regular time studies of nursing service in order to find (1) the per cent of time spent in visiting activities and other time related to these activities; (2) time spent in non-visiting activities and other time related to these activities; (3) the average time involved in making a visit; and (4) the time represented by deliveries, hourly appointments, and other visits of unusual duration. "Time Sheets" became familiar ogres to staff nurses and executives, and supervisors brushed up on all their mathematical knowledge. This system of arriving at the cost of the visit has been followed satisfactorily—though laboriously—and has proved of considerable value as a supervisory device, as a talking point for boards in selling the nursing service by the hour, and has undoubtedly brought an appreciation of the value of the minute to every member of the staff. It is still a perfectly satisfactory method of computing the time chargeable to the cost of a visit.

Those agencies most concerned with the accuracy of this analysis in the administration of services were naturally the insurance companies which pay nursing agencies on the visit basis for the care of policy holders. It was therefore of great interest to the N.O.P.H.N. Service Evaluation Committee when representatives of the companies reported over a year ago that it might be possible to find an alternative and simpler method of arriving at the cost of service, one that would eliminate, at least for purposes of accounting, the day by day detailed time schedules kept by the staff nurses and be just as accurate in the long run as the present method. The Committee wished a little experimentation of the new method before recommending it for general use. Therefore, several visiting nurse associations volunteered to try the new method comparing it on every point with the former one. It gives us great pleasure to announce that the simpler method of arriving at the cost of visit now meets with the approval of the insurance companies, the experimentors, and the N.O.P.H.N. Service Evaluation Committee. The results arrived at tally so closely with the results of the former method, that we feel safe in recommending either of the two methods to public health nursing agencies. We are glad to present this vastly easier method to our readers as a New Year's greeting!

The examples given here and the method have been reviewed by the insurance companies and the Service Evaluation Committee. Questions addressed to the N.O.P.H.N. Statistical Service on the working of this method will be welcome

BASIC FACTORS IN CALCULATING COST

The two basic factors which are used in the calculation of the cost of a visit are:

1. The costs incurred by the agency in making visits
2. The number of visits made.

For agencies with nursing programs which involve *only the making of visits,* the cost of visit determination is a simple operation. For such agencies,

$$\frac{\text{The Total Cost of Conducting Work of Agency}}{\text{Total Number of Visits}} = \text{Cost of Visit}$$

*The Macmillan Company, New York, N. Y., $1.75.

However, for agencies with nursing programs which involve not only the making of visits, but other nursing activities (such as conducting of clinics or conferences, for example), an intermediate step is required in the cost of visit calculation. Instead of using the total expense of the agency for the numerator of the formula, it is necessary to determine that part of it which applies to the cost of making visits. In other words,

$$\frac{\text{The Total Cost of Making Visits*}}{\text{Total Number of Visits*}} = \text{Cost of Visit}$$

To arrive at "The Total Cost of Making Visits," the amount to be deducted (the cost of non-visiting activities) is calculated and subtracted from the total cost. That is,

Total Cost of Making Visits = Total Cost Minus Expense Not Chargeable to Making of Visits

There are two possible methods for determining this deduction for "Expense Not Chargeable to Making of Visits." They are:

(A) The Time Study Basis Method** (present method)
(B) The Visit Basis Method (new recommended method)

Each method is described and its application illustrated below, using the same nursing agency.

A. THE TIME STUDY BASIS METHOD (PRESENT METHOD)

By this method, the deduction is based on the percentage of the field nursing staff's total working time which is devoted to activities other than the making of visits. The steps to be taken in order to arrive at the amount to be deducted are determination of

(1) Total hours worked for the year by all regular, substitute, and relief nurses*** combined (taken from attendance sheets, or daily report sheets if time is recorded routinely throughout the year).

(2) Total hours spent in activities other than the making of visits and other time related to these activities† (taken from daily report sheets of regular, substitute, and relief nurses).

(3) Per cent Deduction $= \dfrac{\text{Total Hours Spent in Activities Other Than Making of Visits}}{\text{Total Hours Worked}}$

(4) Amount to Be Deducted†† = Per cent Deduction $\times$ Total Cost.

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*See part II, Computing the Cost of a Visit, "Principles and Practices in Public Health Nursing," for definitions of costs and of visits.

**Recommended by Service Evaluation Committee as result of Study made in 1929-1930 and described in "Principles and Practices in Public Health Nursing."

***The term relief used here is to designate nurses used for vacation or sickness relief, not "relief" in the sense of nurses employed on relief projects whose time, visits, and costs are kept separately.

†Nursing activities other than making of visits defined on page 95 of "Principles and Practices in Public Health Nursing."

††For simplification the per cent deduction is shown as applied to total cost. However, in some instances it is applied only to certain items of costs, and not to total cost. This is done when total cost includes items which are obviously chargeable in their entirety to cost of making visits.

ILLUSTRATION OF METHOD A

In a given agency there are 4 field nurses whose work involves, in addition to the making of visits, attendance at health conferences and school nursing. The total costs for the year are $7,680* and the total visits 3,249. The method of determining the amount to be deducted from total agency costs as not applying to the cost of a visit calculation using Method A is as follows:

(1) Total hours worked for the year by the 4 nurses = 6,720 hrs.
(2) Total hours spent in activities other than making of visits = 3,877 hrs.

$$(3)\ \text{Per cent Deduction} = \frac{3877}{6720} = 57.7\%$$

(4) Deduction = 57.7% of $7,680 = $4,431.36
(5) Cost Chargeable to Making Visits = $7,680 — $4,431.36 = $3,248.64

$$(6)\ \text{Cost Per Visit} = \frac{\$3{,}248.64}{3249} = \$1.00$$

B. THE VISIT BASIS METHOD (THIS IS THE NEW METHOD WE RECOMMEND TRYING)

By this method the deduction is based on the percentage which the actual number of visits made bears to the possible number which would have been made if all of the field nurses' time had been devoted to the making of visits. The steps taken to arrive at the amount to be deducted are determination of

(1) The number of visits which would have been made during the year by the combined field staff (regular, substitute and relief nurses) if the program did not involve other nursing activities. In order to determine the possible number of visits that would have been made during the year, the number of visits included in a sample of approximately ten per cent of the nurses' Daily Assignment Sheets for each month of the fiscal period should be counted and the total number of visits so determined should be divided by the total number of sheets. The sheets selected should only include those days where the entire day has been spent in the making of visits and where no activities of any other nature have interrupted the visiting program of the nurse.** (In case the organization's program is so arranged that none of the nurses spends an entire day in making field visits, then the selection of daily assignment sheets should be made from those sheets which cover days in which not less than a half day was spent only in the making of visits. If the sample is based upon half days, the sum of the visits included on the Daily Assignment Sheets so selected should be divided by half the number of sheets.) The result is the Possible Number of Visits Per Nurse Per Full Visiting Day.

After the possible number of visits per nurse per day has been determined, it is merely necessary to multiply this number by the total days worked by the entire visiting staff (excluding students) during the year in order to arrive at the Possible Number of Visits for the Year. The Total Number of Working Days Per Year is the sum of the days each member of the staff, including regular, substitute and relief nurses, reported for duty. Fractions of days worked and fractions of days spent by supervisors acting in the capacity of a field nurse should be translated into whole days on the basis of one-eighth day per hour. The number of working days spent by student nurses should not be included in this summary.

(2) The total number of visits actually made during the year. This includes all visits with the *exception of those visits made by student nurses.* Deliveries and hourly appointments should be included as equivalent general visits.***

$$(3)\ \text{Per cent of Cost Chargeable to Visits} = \frac{\text{Number of Visits Actually Made During Year}}{\text{Possible Number of Visits for the Year}}$$

(4) Per cent Deduction = 100% minus Per cent of Cost Chargeable to Visits.
(5) Deduction = Per cent Deduction × Total Cost.

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*For definition of what is included in this total cost see Chapter III, "Principles and Practices in Public Health Nursing."

**It is assumed that each nurse uses but one Daily Assignment Sheet for each day.

***See "Principles and Practices in Public Health Nursing Including Cost Analysis."

ILLUSTRATION OF METHOD B

Using the facts for the nursing agency used to illustrate Method A, the application of Method B is as follows:

(1) The Possible Number of Visits Per Nurse Per Day $\times$ The Total Number of Days Worked by the 4 nurses:
The Possible Number of Visits for the Year $= 8 \times 960$ $= 7680$.

(2) Total Visits Actually Made $= 3249$

(3) Per cent of Cost Chargeable to Visits $= \frac{3249}{7680} = 42.3\%$

(4) Per cent Deduction $= 100\% - 42.3\% = 57.7\%$

(5) Deduction $= 57.7\%$ of $\$7,680 = \$4,431.36$

(6) Cost Chargeable to Making Visits $= \$7,680 - \$4,431.36 = \$3,248.64$

(7) Cost Per Visit $= \frac{\$3,248.64}{3249} = \$1.00$

Thus it will be seen that there are two ways of computing the chargeable costs to be used in arriving at the cost of the visit: (1) That recommended in the handbook, "Principles and Practices in Public Health Nursing," a book that is necessary in determining essential factors in nursing service, and for a definition of terms, and (2) the method suggested here, or what we might call the Visit Basis Method. In both these variations, the fundamental principle of computing cost is the same; it is the method of computation which may vary in different agencies.

It is good business for any agency to know where time is going, its relative distribution, relative cost distribution, cost of various types of services, and the commensurate value of the results being secured in the community from such expenditures of time and money. Time studies, therefore, will always have a place in the well-run organization, but the detailed routine keeping of time sheets for annual cost computations is now unnecessary.

MERRY CHRISTMAS

If we had our way, we would like to be able to say "Merry Christmas" to each of our readers in person on Christmas morning! It has been a red letter year for the magazine—thanks to you! The articles which you have sent us have never been more helpful or more direct in their bearing on present problems, and you have been wonderfully generous in giving time and thought to ways in which to make the magazine better and in writing us about them. Our printers and engravers have worked hard to make the magazine mechanically perfect and good to look at. Many of our advertisers have "stood by" through the lean years and, consequently, are in a better position than ever to go with us into the fat years ahead. Only our subscriptions worry us, and maybe 1935 will show a better record. As we go to press, the President's Committee on Economic Security is meeting in Washington. Things in our professional world are brighter and it is in a mellow, cheerful mood of genuine hopefulness that we wish each and every one of you a very Merry Christmas.

THE EDITORS.

A Staff Nurse Responds to the Challenge of the Survey

By ELLEN D. QUINLAN, R.N.
Hamilton County Board of Health, Cincinnati, Ohio

THE publication of the *Survey of Public Health Nursing** in the United States brings much interest to all concerned with public health nursing. It reveals that over the country as a whole the major problem is the same—the preparation of the nurse for her special job in the field of public health. Our National Organization for Public Health Nursing publishes standards and criteria relating to every phase of public health nursing, organization, administration and program. Our national, state and local health agencies cannot aspire to this high standard unless each public health nurse strives toward her fullest possibilities of achievement.

The challenge of the *Survey* I will attempt to meet in the following manner:

Qualifications: In my own case in order to improve the situation as it now exists, I will try to seize every opportunity in my work through courses, outside reading and contacts to meet the public health aspects of my nursing job. To take advantage of facilities offered by my organization for further study and for participation in staff education programs. I will endeavor to tell nurses who wish to prepare for further study concerning the scholarship and loan funds that may be obtained in our community. As the secretary of the Alumnae Association of my School of Nursing and Health, I feel that I should stimulate interest within our own alumnae to provide scholarships for our graduates. Having had a six weeks' course at Western Reserve this summer, I am eager to tell others of the benefit derived from obtaining a perspective of one's work. I will also urge the prospective young student on entering a school of nursing to select her hospital carefully. I would suggest that she choose a school of nursing incorporating the fundamental theory and experience which are essential as a basis upon which to build further public health nursing preparation and practice.

Community Relationships: With the medical profession, I will aim to establish more definite, friendly relationships with the physicians in my district; to acquaint those whom I do not already know with the purpose of our work and to receive workable suggestions for improvement from these physicians. I will try to achieve and maintain a friendly spirit toward other health and social agencies. This relationship should mean a real understanding of each other's services and a division of responsibility in program and field activities. One method of bringing this about is to make more frequent use of the Social Service Exchange in the community. Exchange facilities are one of the most practical tools by which duplications and gaps can be avoided in service. Not all cases need be cleared in this manner. Selection should be made where health or social situations indicate the need of coöperation of all agencies concerned. I can suggest the value of inter-agency conferences for staff members. This, I know, will be of value in strengthening staff relationships between our own and other health and social agencies.

Lay Organizations: I will strive harder to reach lay organizations and groups, by means of talks and demonstrations. I will aim to be prepared to give information at board meetings, when called upon to do so. I will strive to let my message be heard at school meetings, town hall meetings, pri-

*The Commonwealth Fund, New York, N. Y. $2.00.

vate groups of men and women's clubs, etc. The teachers in our schools need to know more about the wealth of knowledge that a public health nurse has regarding health and proper living. A large number of teachers think of health as being an abstract study. I will aim to make more use of volunteer service, drawing upon the women who have been members of our Red Cross classes in Home Hygiene and Care of the Sick. These members will prove valuable in our infant and welfare clinics in the county. They can be of service assisting with our school examinations. Routine work can be turned over to them such as weighing, measuring and recording. Wherever the nurse can be relieved of routine duties, this should be done. She should turn this work over to another person who can do the work just as well and save her time and energy for the more special type of work she is called upon to do.

Nursing Manuals: I have pledged myself as a member of N.O.P.H.N. to use the *Manual of Public Health Nursing* as an educational device for staff work. Thereby I aim to assist my organization in establishing a better standard of work. The PUBLIC HEALTH NURSING magazine will furnish information for health talks in class rooms, to adult groups, and, in main, provide authentic information relating to all phases of public health work. My membership will be a personal contribution to the work of the N.O.P.H.N. and will also be an expression of appreciation for benefits derived in the past.

Health of the Staff: I will endeavor to comply with the urge of the *Survey* to have periodic physical examinations. I will try to influence other staff members to do likewise.

Reports: A nurse's daily report sheet is a picture of her day and serves as a basis for making the monthly and annual report on staff activities. A well prepared annual report is the most effective means of community education. I will try to contribute my part then, toward the making of a more complete monthly and annual report for my organization.

Nursing Program: Since school work and control of communicable diseases constitute the major part of the County Board of Health work, and I am an employee of this type of organization, I will try to build around this part of the program all the other phases of a generalized health service for which the said organization is responsible. This has been our goal, but we have not always been able to achieve it. We do not provide for bedside care. Our nursing services will have to be carried along lines of teaching and demonstration.

I will aim to visit prenatal cases as early as possible. I will endeavor to make systematic and orderly records of the visits, aim to record just what month of pregnancy the mother was first visited. This often might prove helpful for statistical purposes, as a guide to agencies, in developing a prenatal program. It no doubt will help within our own organization as a stimulus to find our own prenatal cases earlier in pregnancy.

After the child is born, the public health nurse brings to the mother the knowledge and aid which the modern profession of nursing has devised. Through individual home visits, through health centers, through mother's classes, through every channel that is open for communication, the nurse should carry the knowledge and actual physical skills for the prevention of childhood diseases and the promotion of child health. I would aim to give demonstration lectures in connection with our infant and child welfare clinics, at which time counsel can be given to expectant mothers. Literature should not be distributed wholesale, as has often been the case. I would aim to create a wholesome attitude toward the first questions of children which seem to parents to have a sex significance. I would suggest to the mother well chosen literature and would teach that one of the most important factors in giving a child the right start is in the attitude of parents and the atmosphere of the home. I would emphasize habit training.

I will take advantage of opportunities for instructing parents. I will urge better attendance of our parents at the child's physical examination in the

school. For all health supervision service agencies should provide all variety of educational tools for the nurse that will necessarily insure a better quality of service. This calls for adequate supervision, staff educational programs and the stimulus through which she may teach others. Unless the nurse herself knows what and how to teach and is continually adding to this knowledge, these services which have always been considered as the core of any program for prevention and health promotion will remain relatively routine, insufficiently productive and unenriched.

In order to give this kind of service, I must already have planned for my own re-education.

Scarlet fever, diphtheria, measles, whooping cough and all other contagious diseases occupy the attention of the nurse at some time or other when doing school work or a generalized nursing program. I should make an effort to demonstrate some procedure to the family during my communicable visit. I should be ever on the alert to prevent contagious diseases in the schools. I should be observant of unhygienic situations that occur in my district and aim to secure correction by reporting to the proper authorities.

Since I am working with children, I must assist in a childhood tuberculosis program. I must keep abreast with new developments in the tuberculosis field. I must be able to explain to parents the relationships of the fundamental principles of personal hygiene to the control and prevention of infection and disease. I should obtain adequate family histories on all children to be referred for examination (suspicious cases). I should encourage periodic examination of teachers. I should assist the teacher in securing and maintaining a healthful classroom environment. I should be familiar with the early forms of tuberculosis found in children, the adult type of tuberculosis, what is meant by tuberculin, why an X-ray is necessary, and what is the treatment for tuberculosis. Indeed to know all that I can find out in order that I may interpret the significance of diagnostic procedures to parents. I should know the extent of tuberculosis in the community. To determine this I must know the number of living cases reported during the preceding year. This number is usually far below the number of existing cases. I must know the existing measures for control, the number of sanatorium and hospital beds available in the state, county, municipality or township and the relief and other agencies on which she may rely for coöperation.

If any nurse would prove the advantages of generalization, the standard of her work must be as high as that of the specialized nurse. Tuberculosis presents no simple problem.

The nurse doing public health nursing thinks in terms of health; positive health more than mere return to health. Gonorrhea and syphilis occupy unique positions as communicable diseases. For this reason case finding and steering to medical care is often difficult beyond description. I will try to become as well informed along social hygiene lines as it is possible in reading. I will endeavor to know the agencies within my community that are especially equipped to deal with social problems. I will encourage parents to give sex instruction. I will aim to relieve the stigma usually attached to venereal diseases and instruct those whom I have occasion to help that not all cases are the result of sexual contact. I will urge blood tests as far as possible for my prenatal cases.

Education and more education seem now to be within the reach of all. Educators are standing ready to assist in working out educational plans for the individual. Health agencies are realizing their responsibilities in assisting the nurses already employed. More scholarships and more loan funds are being stimulated. In education as in everything else there is a poignant truth in that ancient quotation from Proverbs 13:12 which the N.O.P.H.N. chose in 1912 as its guide and inspiration, "When the desire cometh it is a Tree of Life."

E.R.A. Nursing Institutes in Indiana*

INDIANA was one of the first states to start, under a State Nurses' Advisory Committee, projects for unemployed nurses. By February, 1934, the C.W.A. pay roll for nurses showed assignments as follows:

General staff duty (hospitals)	96
General staff duty (orphanages and infirmaries)	9
Public health projects—local P.H.N.A. supervision (urban)	190
Public health projects—state supervision (rural)	115
Advisory public health nurses—(qualified N.O.P.H.N. standards)	4
	414

From November, 1933, all public health projects were under the direct supervision and administration of the Bureau of Public Health Nursing, State Division of Public Health.

The "projects—state supervision"—were in the main short term nursing tasks wherein an intelligent nurse, guided by the advisory nurse, might do creditable work.

In many instances these projects were carried forward in conjunction with the county medical societies participating in a state-wide immunization campaign. In other counties the project dovetailed with the county medical society's survey or the tuberculosis association's campaign for contact cases. In no instance were nurses assigned until "Standing Orders for Public Health Nurses" had been approved by the local county medical society.

In April the Advisory Committee recommended to the State Director of Women's Work that the public health nursing projects be continued, but with two added stipulations:

(a) that funds for the nurse's transportation and supplies must be provided by the civil sponsor.

(b) that each nurse should attend in her own time the institutes to be conducted for E.R.A. nurses.

The State Relief Administration then set up a budget for the maintenance of a public health nursing project to continue until January, 1935; the project to be both supervised and administered by the Bureau of Public Health Nursing where all reports and pay rolls would be checked for the Relief Administration. The budget provided for the salaries of 132 staff nurses (later increased to 157) and for salary and weekly travel allowances of six advisory nurses.

The first E.R.A. institutes were held in May and June, one all-day meeting for five successive weeks in four sections of the State. There were four advisory nurses at that time working out of the Department of Public Health Nursing. Each advisory nurse was responsible for meeting place, equipment, demonstrations, and attendance.

The burden of the cost of the institutes has been borne by the Department of Public Health Nursing, through the kindly and sympathetic support of the Director of the Division of Public Health, Dr. Verne K. Harvey.

Equally generous has been the American National Red Cross, which loaned its Nursing Field Representative, Margaret Dizney, to the institutes for two weeks; the Indiana State Tuberculosis Association, which loaned its Director of School Health Education, Martha VanMeter, for two weeks; and the several urban Public Health Nursing Associations which sent educational directors and staff members for various demonstrations.

EDUCATIONAL MATERIAL AND PLAN

The textbooks for this first series of classes were "Rural School Nursing,"

*The complete description of Indiana's E.R.A. activities appears in the December *American Journal of Nursing*. We are indebted to Miss Helen Teal, Executive Secretary of the Indiana State Nurses' Association, and to Miss Eva F. MacDougall, Director, Bureau of Public Health Nursing, State Division of Public Health, for this description of the E.R.A. program in Indiana as it relates to public health nursing. The educational program material may be borrowed from the N.O.P.H.N. We hope to publish several accounts of E.R.A. programs in forthcoming numbers. See also page 665 and page 667.

(A.R.C.23), detailed outlines of each institute with bibliographies, mimeographed material (some of it adapted from the N.O.P.H.N. Manual and some from American Red Cross pamphlets), and samples of health educational material which the Bureau of Public Health Nursing furnished without cost. Each nurse on assignment had purchased "Rural School Nursing" at half price (thanks again to the American Red Cross).* Each nurse provided herself with loose leaf folder for the gradual accumulation of what eventually became her manual.

The only other expense to the nurse has been transportation.

The attendance at the institutes was not limited to E.R.A. nurses. All nurses were invited to attend. Personal invitations were given by the advisory and E.R.A. nurses to physicians and to committee members. The State Health Commissioner wrote each local health officer in whose territory there were one or more E.R.A. nurses working, inviting him to the institutes. The State Director of Women's Work wrote each county case supervisor urging her to attend. The Educational Director of the State Board of Nurse Examiners urged nursing school instructors and staff nurses to attend. And the invitations were not lost. One health officer accompanied the E.R.A. nurses to the State Association's convention!

The general outline for the May and June institutes was:

First Institute

Principles of Public Health Nursing
General Objectives
Organization—Committee, Nurse, Volunteers
Community Relationships
Program Planning

Second Institute

Qualifications of Nurse
Content of Home Visit
Demonstration of Home-School Follow-up Visit

Third Institute

The Health of the Preschool Child and His Régime
The Preschool Round-up
What Constitutes Adequate Maternal Care
Content of Prenatal Instructions
Technique
Demonstration of Daily Care of Mother and New Born

Fourth Institute

Communicable Diseases
Demonstration of Communicable Disease Care in Home
Syphilis and Gonorrhea
Sanitation

Fifth Institute

Tuberculosis Service
Demonstration of Instructive Home Visit to Bed Case of Tuberculosis
Health Education, Particularly Adult

Special assistance was given the third institute by the Chairman of the "Committee on Child Health and Maternal Welfare" of the Indiana State Medical Association. He requested the Committee member residing in each institute district to give the address on "The Health of the Preschool Child and His Régime." These practicing doctors' gave valuable and up-to-date points on child health from the physician's point of view.

Especially helpful at the fourth institute were the Epidemiologist and the Chief Sanitary Engineer of the State Division of Public Health.

The second series of institutes preceded the opening of schools. There were then six advisory nurses in the field and six centers were utilized. Each institute covered two days of class work, one day each for two weeks. The content of the instruction built around the theme, "The Nurse's Part in a School Health Program" included

I. Making a Working Plan
II. Deciding Objectives for the Year
III. Program Activities to Carry Out Objectives
IV. Outline for Day's Work in District

In October the E.R.A. nurses were urged to attend the three-day meeting of the Indiana State Nurses' Association which took the place of institutes for that month.

In November a one-day institute is being held in five centers in order that the nurses may be able to compare notes

*The reduction to half price came about through the Red Cross's wish to help with the program and by an arrangement to ship the books in lots to the Bureau of Public Health Nursing. Two hundred copies have been sold to date.

on their program. Nursery school nursing and nutrition will also be discussed. Future institutes will depend upon the continuation of the E.R.A.

Meanwhile, the Committee on Education had been busy. It was instrumental in interpreting the institutes to the nurses as an opportunity, not an obligation. It stimulated the attendance at the institutes of instructors and hospital staff nurses. Late this summer it arranged with the Extension Department of Indiana University to offer "The Principles and Practices of Public Health Nursing" as an accredited course beginning with the fall semester, 1934, and to provide an educational opportunity at home for nurses who wish to take the first step to become qualified public health nurses. The instructor is Virginia A. Jones, the Assistant Director of the Bureau of Public Health Nursing.

Seventy-two nurses are now enrolled for this course in Lake County, where it was first offered. One-fourth of these nurses are E.R.A. nurses. The others regularly are employed in institutions, schools or community nursing projects.

HIGH STANDARDS SAFEGUARDED

This account should not be closed without some word of appreciation for the unique support given nursing by the first Director of the Civil Works Administration, Mr. William Book, and the first Director of Women's Work, Miss Florence Kirlin. In November, 1933, before any nurse-assignments were made, an Advisory Committee on Nursing was appointed

(1) to devise projects of work relief for registered graduate nurses
(2) to select communities where desirable projects are needed and could be established
(3) to prepare a guide for the selection of work-applicants.

The recommendations of this Advisory Committee submitted to the Director of Women's Work were never questioned except for clarification, and were never set aside but once and that to increase the amount earned by the individual nurse!

Similar support of nursing standards is given by the State Department of Public Instruction, where nurses assigned as health teachers under E.R.A. must meet the American Red Cross requirements of home hygiene instructors to teach that course.

Though we recognize the weakness in the present set-up, particularly the weakness in the amount of supervision, we have seen the quality of work and volume of work mount, the nurses happy and hopeful, and we now feel that E.R.A. will eventually reveal itself as an instrument for improved community nursing services.

THE PUBLIC HEALTH NURSE HOLDS A KEY POSITION

If maternal deaths occurred in any one time or period, or in any one place more than in another, it would be a comparatively simple matter to arrange for more intensive work at such times and in such places. The truth of the matter is, however, that maternal deaths are scattered widely and so it is necessary to work to save all mothers. A single home or clinic visit may have beneficial results, but studies show that the largest proportion of mothers who die have had the least amount of nursing supervision. Nursing care can not take the place of medical supervision, and patients should be made aware of that fact, but a public health nurse can do an immense amount for any woman who will make known her condition early in pregnancy. The will to do, coupled with a systematic, methodical plan of contact in home or station or clinic can accomplish what others less privileged are unable to achieve.—*Health News, New York State Department of Health.*

"Lay Participation" *

A Tribute from a Lay Committee Member to a Nursing Group

By ADA GREENFIELD McRAE

Chairman, Lay Committee, Royal Oak Township Branch of the Detroit Visiting Nurse Association, Michigan

IT has been my privilege to have served during the past two years as chairman of the lay committee of the Royal Oak Township branch of the Detroit Visiting Nurse Association and I am happy to give my testimony as to the personal benefit which I have derived from the experience and possibly offer a guide-post to new members of lay committees who may feel somewhat at sea as they take on their new duties.

Through an unusual set of circumstances I became chairman of our lay committee before I had become familiar enough with the work of the Visiting Nurse Association to be of much value, but fortunately I was aware of my lack and set about, through the help of our director of the nursing staff, to correct my deficiencies.

I studied a history of the development through the past thirty years of the Visiting Nurse Association in Detroit and followed carefully the development of the various suburban substations particularly my own, the Royal Oak Township station. I also became as familiar as possible with the public health situation in Oakland County and especially my own community. I then began to have a background upon which I might try to silhouette the work of the Visiting Nurse Association.

By this time several months had passed and I began to see that it was quite as necessary for *all* of the committee members to become informed and so we have studied together.

As chairman it has been my duty to attend a monthly meeting of the Detroit Board of the Visiting Nurse Association and that has been a revealing experience. Statistics to me had always been merely something to be endured in a report, but behold! the director worked magic with statistics. How could I have been so dull before as not to have guessed that back of them lay heartache and discouragement and all the other blights of poverty. I have come to see that statistics are as important to a social worker as a compass to a traveler.

It seems to me to be one of the most important duties of a lay committee, after each member has made herself as well informed as possible, to interpret to the public what they as a committee have found, that is, facts about the causes and results of sickness and poverty in their own communities. To be sure "the public" is for the most part a large group of indifferent people quite unaware of the fringe of underprivileged people around the edge of their comfortable world. A wide awake, purposeful lay committee may do much toward leavening that mass of indifference.

A good lay committee member will see readily the connection between sickness, misery and heartache among the needy group in her community and such resources as well-baby, prenatal, and maternal health clinics as well as playgrounds, employment insurance, workmen's compensation and old age pensions. The lay committees' business then is to see that the public sees the connection and it will be a test of their ingenuity to find interesting and perhaps unusual ways of presenting this all-important information.

The reward for a lay member—if we must ask a reward—is great, for it is the deep satisfaction of having had a small part in the great onward movement looking toward social justice.

*This and the following article came to the N.O.P.H.N. unsolicited. The Editors put them together.

"Lay Participation"

A Tribute to a Lay Committee from a Nurse

By EMMA T. HIGGINS, R.N.
County Nurse, Waukesha County, Wisconsin

THE recent enlightening survey of public health nursing undertaken by the National Organization for Public Health Nursing states . . . "As for participation of lay citizens in the work of public health nursing agencies through organized groups or through individuals who volunteer assistance, there seems to be room for a great deal more development in this direction."*

In recent years I believe public health nurses, particularly those working alone, have come to the realization that lay participation is an absolute necessity in their work. Such has been the case in my county. In the dear departed days of 1929 when I first came to Waukesha County, Wisconsin, as county nurse, the work was carried on by the nurse under the direction of the county health committee, with no active assistance from lay groups or individuals. It is true that a County Council of Women's Clubs had been interested for more than ten years in the work of the nurse. In fact, the organization had been formed during the days of the World War for the express purpose of obtaining a county nurse. But, after the work had become an established part of the county set-up, enthusiasm faded, and the group came to hold only an annual meeting at which the nurse reported the year's activities and gave a résumé of the corrective work which had been accomplished through the use of the hundred dollars, more or less, which the Council raised for that purpose. This handful of women was sincerely interested but, since there appeared to be no work for them to do, their assistance became mostly of a financial nature.

A CALL FOR HELP

Then came the gradual, almost imperceptible increase in relief work through the years 1930 and 1931, the growing number of children whose defects remained uncorrected from one year to another, the pressing calls for clothing and milk and food. Slowly, insidiously, came the realization to the nurse that Waukesha County, with its 32,000 rural population, with its 7,000 school children, with no social service department, with the old township and village system of relief and with no dispensary or county hospital, was placing an unbearable burden upon the shoulders of one person, herself. Bewildered and despairing, she sought advice from the sympathetic and resourceful chairwoman of her committee and from other women who had evidenced unquestioning devotion to the cause of childhood. Shortly thereafter the solution came.

THE RESPONSE

The old County Council of Women's Clubs, under the leadership of its forceful president, became, almost overnight, the Waukesha County Council for Child Welfare, with official representatives in every one of the county's thirty-four precincts. An intensive drive for memberships and funds was inaugurated, representatives were charged with, and accepted, responsibility for their own communities, and the County Council for Child Welfare became an active, obstacle-surmounting defender of the forgotten child.

Who were these representatives and what did they do? They were society women, housewives, farm-women, mothers; they were women who were free from care, and women who were struggling frantically to keep their farms and their homes. But when they were called upon, they became as one in the im-

**Survey of Public Health Nursing,* The Commonwealth Fund, New York, N. Y. $2.00.

memorial manner of women who have always planned and hoped and fought for children. They collected and renewed old clothing and distributed it to needy families; they drove their own cars and used their own gas to get help to the destitute; they aroused local pride in caring for local responsibilities; they found moral and financial help for the Council's endeavors; they made up Red Cross goods for mothers who could not sew; they formed local committees to help with Council projects; they took children whose defects were crying for correction to family physicians and dentists, and arranged for the work to be done at Council expense. They did anything and everything that fine, intelligent, humanitarian women can do for less fortunate people.

AN ESTABLISHED INTEREST

These women, and each year, more women, are doing this work in Waukesha County. The Council has now grown to include hundreds of individuals and organizations in its membership. Hundreds of dollars have been raised each year to correct minor defects in children, and, while this fund is not nearly enough, these women have performed miracles in stretching it to improve health conditions for hundreds of neglected youngsters.

Last year about fifty women appeared before the County Board of Supervisors to ask for a children's center. They were rebuffed, but this year they are back again with the request for any sort of an appropriation to help care for the many county children who need dental work and spectacles and tonsil operations . . . . those little but vital things which may mean health or future success or even life itself to our youngsters. Our present system of medical relief in Waukesha County makes it easier to obtain any number of major operations for persons on relief than to arrange for one ten dollar pair of spectacles or one tonsil operation. It is far simpler to secure a pension for a blind person, or to get hospitalization for a mastoid case or a youngster with heart disease, than it is to take steps to prevent these conditions. May the County Council for Child Welfare find the way to remedy these shortcomings!

If this article appears to be more of a eulogy for the members of our County Council and less of an explanation of the organization's set-up, it is because the Waukesha County nurse is overwhelmed with the thought of what these women have accomplished and to what avenues of opportunity they are leading her. She is convinced that lay participation pays large dividends.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR DECEMBER, 1934

Experiences of an E. R. A. Nurse

By NINA BARTON, R.N.

E.R.A. Public Health Nurse, Wayne County, Utah

AN extensive dental program has been carried out in Wayne County during the month of September. Ninety per cent of the children in the county have been examined and a large number of children between the ages of four and sixteen has been cared for. The work has been made possible by the coöperation of the local health committee in each town of the county, directed by a central committee and the county nurse.

The work is the first of its kind ever done in this county, and it is hoped that various child health programs can be carried out as their necessities may arise. This can only be made possible through the employment of a county nurse. Due to the isolation of Wayne County and the impoverished condition of the county treasury, a nurse has never been employed until the present relief measures provided the county with E.R.A.* help.

There is a vast field for this type of work in this county and others so situated.

A good example of the necessity for a continuation of public health nursing is the recent typhoid inoculation program sponsored by the State Board of Health and carried out by the F.E.R.A. nurses.

ONE DOCTOR IN EIGHTY-FIVE MILES

In this county there is one young doctor, whose territory covers a distance of eighty-five miles. It was impossible for him to do the inoculation work, so he asked the nurse to take it over. Through the organization of the Children's Health Committee, the nurse was able to inoculate 1,371 people. A minimum charge of ten cents was made—the proceeds going to help defray the cost of the dental work. Those unable to pay the ten cents were inoculated free of charge.

The following story concerns my adventures during the inoculation of the people of Cainville and Hanksville, Wayne County, Utah:

When I planned my trip, I had no idea of what the country was like, so I asked the doctor's wife, a midwife, if she would help me (she had assisted me in other inoculation parties).

"Yes," she replied, "but there are two things you must do before we go. One is to have your car in shipshape order, and the other is to get you some decent clothes."

I thought I was dressed as well as most of them. My uniforms were well starched and ironed, and I was sure I could not afford more. However, I agreed to let her take me to the general mercantile store to get "something better." To my complete mortification, she asked the clerk for two pairs of large-sized overalls. "My only regret," she replied to my remonstrance, "is that we must use new ones instead of second hand ones."

At five o'clock the following morning we started out, armed with a shovel, rope, and plenty of water. Mrs. B. (the midwife) took the wheel, explaining that regardless of my ability to steer Bertha (a Model A Ford) through the streets of Salt Lake City, I did not possess the experience to drive her where we were now going.

We drove for three and a half hours before we finally came to our destination. Such winding, rocky roads and such riots of unpaintable scenery made that first trip a true scenic expedition. As soon as we arrived in Hanksville we

*To our foreign readers: E.R.A. stands for Emergency Relief Administration—State bureaus set up at the request of and either in part or fully financed by the F.E.R.A.—Federal Emergency Relief Administration in Washington, D. C.

were told to call on a woman who was expecting a baby, and who was not feeling "so well today."

We finished our inoculations and then went to see her. She lived on a lonely road, three miles out of town, in a one-room shack with canvas for windows and good intentions for walls. It was in this environment that the woman intended to be delivered.

ONE BED FOR SIX

We found her in pseudo labor, determined to have her baby while we were there. To satisfy her, we took our blankets out on a knoll in front of the house and slept. (They possessed one bed for a family of six.)

The next morning the woman felt much better, so we tried to convince her that her baby would not be born for another ten days at least. We promised that we would make our next trip down there on the date she should be confined (though, of course, we knew that we could no more foretell the exact date than she could). We begged her to get out, in the meantime, where there was good help; but she said they hardly had flour enough for another batch of bread, let alone to move out, pay a doctor, nurse, and board bill. We argued with her and her husband but to no avail. We left with misgivings as to what would happen in that lonely cabin if she should be alone when her baby came. We knew that it would be impossible for the doctor to get there in time to help her once she started in real labor, so we determined to see what could be done about the matter.

We found we could not get E.R.A. help. Neither could we get aid from any other source, so we decided to go back on the day set, and let fate do the rest.

Ten days later we again set out. This time I drove, Mrs. B. saying that it was my turn now. What a drive! We called on our woman before we made any inoculations. To our amazement she was in real labor and not a soul within three miles to help. She did not have a newspaper, pad, nor a drop of lysol. We had anticipated this and had brought lysol, cotton, and sterile gauze, "in case of emergency." But under conditions, we did not have enough help or any linen so we figured that we would have time to do the inoculations and bring some help back with us. However, we took the patient with us, just in case——

A BABY IN A CLOUDBURST

We hurriedly did our work while the women in the small isolated town gathered baby clothes, papers, and sheets. We then gathered up our charge and her family (she insisted that they could be turned out in the hills during the confinement). We also took two neighbor women with us to help. By this time she was having regular contractions so it was necessary for us to show considerable speed, especially since a heavy storm seemed to be brewing in the north. By the time we arrived, the wind was blowing a terrific gale, and the women informed us that it meant a cloudburst. We hurriedly built a fire and sent the children out. The storm proved a *howling success*. It not only blew sand and sagebrush through the house but it turned into the cloudburst as predicted; and it was necessary to call the children into the house to keep them from being washed away. Mrs. B. dashed out to pull a canvas over the window and came back drenched.

What a mess! Mud an inch deep over the floor, a wet bed, a woman in labor, and seven or eight small children huddled up in the delivery chamber. Fortunately, the storm subsided before "things" began to happen and the children were hustled outside to play in the flood water. A baby boy was delivered soon after; and in spite of conditions both mother and child lived. Food was sent from the neighbors, and by eleven o'clock the house and patient were quiet. We had horses brought and rode three miles through the flood to a bed.

The next morning we visited our patient and had the car dug out of the deep, wet sand. Our return home was uneventful, though on the next trip down to do the third inoculation, it was necessary to ride bareback on an old white mule because Bertha figured "enough was enough" over such roads

and through such ruts. We had to take her carbureter out with a pair of dental forceps (we had forgotten our pliers), and clean it up, clean out the gas line, tinker the whole engine over, and all that was wrong (the mail driver made the diagnosis) was a crack in the distributor!

The experience was a little trying on each trip, but it was worth it to us, and I am sure the people appreciated our visits for we received such a hearty welcome and such wholehearted support from most of them. Their superstitions are such that it would take a nurse, doctor, and minister several years to weed them out, but the people's hearts are in the right place and they deserve more attention than they have had up till the present time.

Emergency Nursery Schools

By FRANCES J. PLEASANTS, R.N.

Supervising Nurse, School Administration Building, Richmond, Va.

DR. George A. Williams, Director of the Emergency Educational Program for Virginia, authorized the opening of emergency nursery schools in Richmond on January 19, 1934, as an educational project.

As an unemployed nurse, I entered this new field of activity as supervising nurse for these nursery schools. I had just completed a postgraduate course in pediatrics at Bellevue Hospital, where training in nursery school education is emphasized. During this course, I was able to observe in many of the outstanding nursery schools in New York City. Immediately, I realized the possibilities of building up a worthwhile program in Richmond.

With the assistance of Dr. Winifred E. Bain, Advisor in Nursery School Education of New College, Columbia University, we were able to formulate an effective plan for the development of our nursery schools. This plan compares favorably with that set up by the Government and meets our specific needs in Richmond. We were fortunate in having a training institute for workers interested in nursery school education. This institute was under the direction of Grace E. Mix, State Teachers College of Farmville. The classes were conducted by prominent doctors and educational authorities who were well equipped to take up the various phases of this work.

Our schools were set up in the public schools where possible. Others were established in community centers loaned to the public school system for this purpose.

The plan calls for a head teacher and an assistant in each center. A nurse serves two schools in the capacities of nurse, teacher, and social worker. A dietitian supervises the preparation of the lunches which are served at noon. My work, as supervising nurse, has been to visit these centers and make suggestions for their improvement, attempting to develop the best possible program. The entire staff is under the direction of the Educational Relief Director of Richmond and the Medical Director of Richmond Public Schools.

The children—twenty at each center—were recruited from homes on relief. Their ages range from two to five years. In a few cases, children over five years of age have been accepted, when their cases showed great need of nursery school training because of social or physical conditions in their home.

The proper equipment and play materials were started by the C.W.A. This project was not completed by March 31, therefore it is to be completed by the Works Division. Much valuable equipment has been donated by interested individuals. The American Red Cross has helped greatly in furnishing one hundred blankets and much needed clothing.

FED ON FIFTEEN CENTS A DAY

The Home Economics Department of Iowa State University and the United States Department of Home Economics worked out the menus which we follow. With an appropriation of fifteen cents per child daily by the Federal Government, we are able to furnish the proper foods, plus milk and fruit juice, to each child.

The parents of our children have not been able to care for them adequately during the past few years. It has been our duty to educate them in the proper care of their children, to stimulate pride in their offspring, and to appreciate the fact that the child has a definite place in this world.

These six schools have been in existence since January, financed by the F.E.R.A. and C.W.A. funds. By the end of March, the value of this nursery school program had been so clearly demonstrated that the enthusiastic staff carried on for one month without the assurance of being paid for their services. However, a change in set-up made it possible finally for the staff of thirteen teachers and five nurses to be reimbursed for that month during which they had worked gratis.

HEALTH SUPERVISION

Among the benefits offered by the nursery school are the application of medical treatment by complete physical examination and reference to local doctors, or clinics; the provision of recreation and proper nourishment; the promotion of health; and mental and physical development. There is a general improvement in the health of the children, decidedly noticeable in those having rickets and other nutritional disturbances. Their parents have been instructed to administer cod liver oil, which they have obtained from the clinics.

In the home of the under-privileged child, circumstances very often will not permit the serving of three meals a day. In many of these homes, should there be three meals a day, we would still have cases of malnutrition, due to a lack of knowledge of dietetics.

Efforts are made to weigh the children at regular intervals and records show an increase in weight in seventy-five per cent of the children.

Upon admission each child is given a complete physical examination by the school doctor. A record of this examination is kept in the school, and one is sent to Nursery School Headquarters in Washington. When defects are found, the nurse makes it possible for the parents to have corrections made. The children in all of our centers have improved in their habits of hygiene and behavior. We find them very quick to grasp the difference between cleanliness and uncleanliness of body and of clothing, and the desire to be tidy is now well established. They respond to the rest hour and most of them sleep soundly. There is greater activity in play, and every child has acquired a knowledge of songs, rhymes, stories, and games.

TALKS WITH PARENTS

Meetings have been held at the schools with the parents in the interest of the children's welfare. Individual problems pertaining to health and behavior are discussed. Every effort is made to assist the parents to maintain good health and to know the value of proper foods. The parents have expressed their appreciation and gratitude for the privilege of sending their children to school and for their improvement, evidenced by habit development and better health.

We agree with Mrs. Eleanor Roosevelt that this program meets a social need in every community and should become a permanent program.

A Health Week in Far-off Bengal

By SISTER M. FRANCES, R.N.

The Dacca Health Week is an annual health education project conducted by the Sisters of the Society of Catholic Medical Missionaries in Dacca, Bengal, India. The Society has charge of the nursing in the government hospital and runs two health centers there for women and children.

Sister M. Frances Herb, R.N., joined the Society in 1928. In India she spends most of her time in maternity and child welfare work among the poorer classes of Hindus and Mohammedans in Dacca, Bengal.

THIS year our Health Week was a great success. The first day, the doctor gave a lecture to the mothers on child welfare. The Mohammedan mothers as well as the Hindus attended it. Then all of the babies were examined by the doctors and we assisted. Many babies were suffering from various ailments and one or two were really ill, their mothers being unaware that anything was wrong. When it was necessary, the doctors advised treatment. As a great many of them suffered from rickets, enlargement of the liver, and skin diseases, the really healthy were few and far between. A mother living among the poor of Dacca and possessing a well-cared-for and healthy baby surely deserves a medal. Unfortunately, the poor have not much of a chance and most of the medals go to the babies who are brought up under better conditions.

We had six different centers for examining the little ones. At the second one there were mostly shoemakers' babies. The families were not very poor but belonged to a very low caste. Therefore they had had no social contact with the better caste Hindus nor had they had any education and in consequence had become very "jungly." They were not anxious to bring their babies for they knew too well how they would be treated by the better caste Hindus. They were made to wait until the other babies were all taken care of. One of them, however, won a prize and another was a very nice baby. I hoped she too would win a prize, so when I called on the mother to ask her to bring her baby, I told her to give it a bath and put a clean dress on her. In answer to my suggestion, the mother said, "Now look here, *Mem Sahib*, she has already had a bath today. If I gave her ten baths do you think she would be your color?" Now a bath consists in holding the baby under the water tap on the street for a few minutes—no soap and no warm water—and then the baby dries in the sun. Of course the ears, scalp, etc., have a good accumulation. So little Rani came, none too clean, and did not win a prize. We had sixteen silver medals for the prize babies. Silver is very cheap, so we could get quite a number.

The Health Exhibit was held in the garden of the Nawab (a wealthy Mohammedan). It had a high wall all around it and was strictly *purdah*. On the morning of the exhibition the rain came down in torrents. It was really a blessing in disguise for by noon it had dried off sufficiently and the day was cool and delightful. In other years it has been uncomfortably hot. There was a large attendance and everyone seemed very much interested in the lectures. Lectures were given on tuberculosis, malaria, and leprosy, all three diseases being prevalent here. Then we gave demonstrations of the care and feeding of the baby, the sanitary and the unsanitary delivery room, antenatal care, etc. I really believe that many of them learn something, and it is the only opportunity the mothers have to learn anything of the kind.

After the various demonstrations, the medals were given out. This was followed by a very pretty Indian play put on by the high school girls. It was nearly six o'clock when the play was over. Then came the outdoor movie. It was an old film, a health picture, but new to most of them, and almost all of the women stayed for it. No men being permitted in the garden, they had put the machine on the wall, and the operators sat on a platform behind the wall. They had drenched the screen with water and the picture showed through beautifully on the other side. In this way the screen also served as a shield for the *purdah* ladies.

At about seven-thirty the moon rose and when at eight the picture was over it was a very beautiful moonlight evening. The workers had all had a very busy day and were pretty tired, so we tried to get the people to go as soon as possible. This was not very easy since, for many of them, it was their only outing for the year. The majority left, some very reluctantly, and the rest went to the Nawab for permission to have family parties in the garden later in the evening. Permission was given and there were several family parties. The graceful palms and many flowers made the garden look like fairyland in the moonlight. It was ten-thirty before the great day came to a close by the departure of the remaining guests.

An amusing aftermath occurred a few days later when a Mohammedan woman brought her grandson to me saying, "At last I've found you in. I came three times and you weren't in. I've brought Dil Mahommed for his prize." Dil was a rather delicate baby of one and one-half years. He was nice and clean and resplendent in his Idd clothing (Idd, the great Mohammedan festival, had been a few weeks previously), which consisted of a bright shirt and trousers, black patent leather slippers, and an imitation velvet cap embroidered in gold. His eyebrows and eyelashes were penciled and shaded and the upper part of his face was powdered. The grandmother was very sad when I told her that there was no prize for her darling. Had we manufactured one, we would have been besieged with similar requests. After long explanations she became resigned. I gave her some suggestions on what to do for her rheumatism and for her daughter's fever and she went away.

A Class of "Dais" or Native Midwives at the Health Center in Dacca of Which the Mission Has Charge

Prenatal Group Instruction

By RICHARD A. BOLT, M.D., and ELLA GEIB
Cleveland Child Health Association, Ohio

PRENATAL group instruction, started in Cleveland in 1922, came under the direction of the Cleveland Child Health Association in June 1932. A statistical study of this service as carried on in 1933 has brought to light some interesting facts.

Eight lectures given by a specially-trained, experienced public health nurse comprise each series of the lecture course. In addition, mothercraft classes are held in which the mothers are taught to make layettes and are given an opportunity for personal conferences with the lecturer. In 1933, six lecture courses and three craft classes were held weekly for clinic patients at three Cleveland hospitals and the University Public Health Nursing District, and three lecture courses and two craft classes for patients of private physicians, one being at the Academy of Medicine and two at branch stations of the Visiting Nurse Association. Mimeographed lesson outlines with bibliography are given at the lectures.

Patients may repeat the lectures if they so desire. One patient attended 19 lectures. The average number of classes attended by patients of private physicians was 6.9 compared with 3.3, 3.5, 4.0, and 5.2 for clinic patients. The average for the whole group was 4.2. The large number of classes attended by some clinic patients is accounted for by the fact that they usually were at the clinic for long-time treatments and attended the classes each time the clinic was visited. The fact that patients coming to clinics primarily for treatment would attend these classes also accounts for the large number of persons attending from one to five lectures.

A total of 1,835 cases were reviewed for this study, including new cases in 1933, cases carried over from 1932, and postpartum cases.

There were 123 postpartum cases, that is, patients who did not attend the classes until after delivery or miscarriage took place. Ten miscarriages were reported in this group and also three infant deaths, one of which was premature, one stillborn, and one full term.

Reports of deliveries were available for 1,412 of the prenatal cases. In addition there were reported 17 miscarriages and 2 abortions. Seven of these mothers died; but two of the deaths were from causes not connected with pregnancy. One death followed a miscarriage.

There were 1,410 live births and 8 stillbirths reported for the 1,412 prenatal cases, there being 6 pairs of twins. Taking into consideration the 5 deaths from puerperal causes, the maternal mortality rate was 3.5 per thousand live births compared with the general Cleveland city rate of 5.9 per thousand live births. If deaths following abortions and miscarriages are deducted, as they should be, the rate for 1933 in the prenatal instruction group was 2.8 compared with the city rate of 4.8.

Eleven babies born alive to these mothers died shortly after birth, seven of which were premature births. In addition seven stillbirths were reported. Two of the premature babies born alive are still living. Records indicate deformities for only three of the living babies, one hare lip, one eye condition, and one with a hip joint abnormality.

Complicated deliveries were reported for six of the mothers who lived: 1 episiotomy, 1 cæsarean section, 1 precipitate, 1 porro-section, 1 heart case, and 1 hard labor with blood transfusion. The seven deaths were due to: 1 burning, 1 carcinoma, 1 puerperal infection, 1 edema of lungs, 1 bronchial asthma, 1 following miscarriage, and 1 for which cause is unknown.

Making comparisons of the various districts, it is interesting to note that

no maternal death occurred among the patients of private physicians who attended these classes and that the only infant death was a premature baby. Classes at Hospital A show a similar record with no maternal deaths and only one premature infant death. Hospital B classes had one maternal death and one death of a full-term infant. The two deaths to mothers in Hospital C classes were from causes not connected with pregnancy; one premature death and one stillbirth occurred in that group. Eight of the miscarriages and two abortions took place also among the patients in Hospital C classes.

The group at the University Public Health Nursing District, which is largely a Negro and foreign group, had the highest mortality. Four maternal deaths, seven infant deaths and six stillbirths were recorded in this group. One of the maternal deaths followed a miscarriage, eight other miscarriages being reported.

Ages of mothers attending the classes ranged from 15 to 48, including a small number of unmarried mothers. Ages of mothers in clinic classes showed greater variation than in cases of private physicians, ranging from 15 to 48 for clinic patients and 18 to 33 for patients of private physicians.

Eighty-one of the 99 pregnant women attending the classes for patients of private physicians were expecting their first baby, two para V being the highest in this group. The hospital clinic cases showed much greater variation, from para I to para XVII. The largest group were para I to III, with a considerable number of para IV to VII.

The greater number of patients started the classes during the fifth to eighth month of pregnancy, although large groups also entered during the fourth and fifth months. *Seven patients came in as early as the first month of pregnancy*, and 27 women who were not pregnant also attended the classes. Patients of private physicians did not differ greatly from clinic patients in the time of their initial enrolment in the classes.

MATERNAL MORTALITY IN ENGLAND

Figures from the annual report of work done by the Queen's Institute of District Nursing make us envious of England and Wales, so compact and well-nursed are these areas compared to ours. We quote from a summary, published in the *Queen's Nurses' Magazine*, September, 1934:

Report on Midwifery Cases Attended by Queen's Nurses and Village Nurse-Midwives During the Year 1933

Number of Queen's Nurses		1,000
Number of Village Nurse-midwives		2,855
Number of cases attended		64,144
(No doctor engaged for confinement)		
Of 62,923 cases 14,044 were primiparæ, 22.3%		
Number of times medical aid sent for:		
For mother	19,157	31.5%
For infant	3,472	5.4%
For the mother during pregnancy		5.6%
For the mother during labor		21.5%
For the mother during puerperium		4.5%
Number of forceps cases	4,553	7.1%

The number of maternal deaths is 145 (of which 38 or 26.2% were primiparæ and 38 or 26.2% had had five or more previous pregnancies). This mortality rate is 2.26 per thousand as compared with 2.1 per thousand in 1932 and 1.7 per thousand in 1931. The rate is 2.3 per thousand in urban districts and 2.2 per thousand in rural districts.

Causes of Maternal Deaths:

Sepsis	49 cases	33.8%
Accidents of labor	37 cases	25.5%
Eclampsia	4 cases	2.8%
Embolism	20 cases	13.8%
Complications	35 cases	24.1%

Among the Fields

Dear Staff Nurses:

Lend me your ear and I will tell you about Mrs. Field, my prize prenatal. Really there is not much to tell as she is apparently a very normal prenatal, but I am still a bit uncertain as to who won in the argument we had regarding the value of prenatal care.

Mrs. Field was referred to us by the State Relief, who requested that we should endeavor to get her to attend the County Hospital Clinic, as her husband is unemployed and they have no funds whatever.

I arrived at Mrs. Field's on a very hot afternoon to find my patient very pregnant and busy with a very large and uninteresting ironing. I introduced myself and said Miss A. of the State Relief had asked me to call and see if I could be of any assistance. The answer to all this was dead silence except for a very decided sniff. However, Mr. Field came to my rescue by bursting into the room and demanding I get him a job and then they would need no help about the baby.

I admired the garden and several small Fields standing around and started bravely out again and gained this much information: the Fields have eight children ranging from one to nineteen years and all have been born at home with no prenatal care to speak of. They had always been able to scrape together enough money to pay their own doctor, who very seldom got there until the baby was born; therefore, Mr. and Mrs. Field will just wait until the time comes and somehow a doctor will be provided, but the thought of having the visiting nurse does not fill Mrs. Field with great joy.

All the children at home were exhibited and I was to tell them if I had ever seen any healthier, and what was the use of going to a doctor for prenatal care?

By this time I was a little overwhelmed by the Field family, so retired from the field with a promise to return soon and a feeling that I had lost out in the first round. May I say that during the whole visit Mrs. Field continued to iron and, as she had a bad head cold, to sniff.

On June 12, I called again on Mrs. Field and was received a little more graciously, so proceeded to explain the hospital home delivery plan, which met with great favor except for the visit to the hospital for prenatal examination.

However, after much persuasion Mrs. Field will let me know in a week whether she will go to the hospital. As this is her eighth month of pregnancy, I am naturally anxious for her to decide. I inquired about the layette and found I could supplement her clean but rather scanty one. Out of a clear sky Mrs. Field informed me, she could have the insurance nurse as she had a paid-up policy, and when I explained I was that very nurse, Mrs. Field thawed perceptibly and said if she had known I was as nice as Miss B. she wouldn't have been so mad at my first visit. I can ask for no greater praise than to be likened to Miss B.

As it happened I had to depart on my vacation, leaving Mrs. Field on the verge of going to the hospital clinic, but I did not feel very hopeful, as she seemed determined to have the baby minus medical care.

I called on Mrs. Field on August 15, to find her very well and in the midst of canning five crates of apricots, not in half-pints such as a spinster nurse would use, but hefty two-quart jars. Right here let me tell you that my idea of rigid economy is: the little Fields shelling the apricot pits and stoning the nuts for Christmas use.

After admiring such ambition, I casually mentioned doctors and clinics, and was told the sad tale: Mrs. Field had attended clinic and had had her first examination in nine pregnancies, and she did not think highly of the procedure. However, she *did* like the doctor and arrangements were made for home de-

livery, and Mrs. Field was to return to clinic in two weeks. On her return to clinic, she found a new doctor on the service, and she was to be examined again, so she decided against clinic care and departed for home very mad at everyone. Almost at once Mr. Field secured a job at $90 per month and great was the rejoicing when a private physician was engaged to deliver the tenth Field.

Came the great day, and as was predicted, Mrs. Field delivered a normal male child without benefit of physician or nurse. However, Dr. C. arrived in time to tie the cord and all was well.

I gave Mrs. Field postpartum care for eight days, and each day gave demonstration care of the baby to five little Fields, and never have I had such attention paid to instructions. By the eighth day they were checking up on me!

Mrs. Field was really very grateful for our care and in spite of many arguments, I feel our service was of great value to her, and certainly I learned a great deal in my contacts with this family. In spite of desperate poverty there were cleanliness, happiness, and contentment in this home, and a joyous welcome for William Field.

Yours for adequate prenatal care,

GRACE OLIVER, R. N.

Seattle Visiting Nurse Service,
Washington.

IMPORTANT MAGAZINE ANNOUNCEMENTS

A renewal notice is always placed in the front of your magazine to warn you when your subscription is running out. We always send you the magazine the following month to be sure there will be no break in your files. After that, no check, no magazine! Won't you watch for the yellow slip and renew your subscription promptly? No receipt will be sent for subscriptions unless subscribers request it, and unless a subscriber notifies us of failure to receive the magazine within four months of such failure, the missing back numbers cannot be supplied free of charge.

Warning: A man giving the name of Ray A. Hagerty is soliciting subscriptions for PUBLIC HEALTH NURSING. He has no connection with us. Do not subscribe through any *individual* soliciting subscriptions unless he has a letter from us authorizing him to act as our agent.

HOW TO USE THE INDEX

The index to the 1934 numbers of PUBLIC HEALTH NURSING appears as always in this, our December magazine. "Reviews and Book Notes" are indexed separately at the end of the general index. It is always quickest to find an article by looking up the author's name. If the author is unknown, look under subject. In every magazine there are two sets of paging—one for the advertising section, one for the text. Numbers in the index *always refer to pages of the text* and the month may be found by referring to the first leaf of the index where a table of months is given by pages. Thus, "Industrial Nursing, 343" will be found to fall within "June, pages 275-353."

The index is not printed separately. Extra copies of the December magazine may be purchased at thirty-five cents (25 cents to N.O.P.H.N. members).

LAST MINUTE ADDITIONS TO N.O.P.H.N. HONOR ROLL

*** American Red Cross, National Headquarters, Washington, D. C.
*** Nevada Public Health Association, Reno
** Metropolitan Life Insurance Nursing Service, Nashville, Tennessee
*** Attic Angel Association, Sponsors of Visiting Nurses, Madison, Wisconsin

Stars indicate number of years staff has held 100 per cent N.O.P.H.N. membership

Depression Cribs

The first suggestion comes from the Visiting Nurse Association of Cleveland, Ohio. The drawing is by Ruth E. Dilley, R.N., a staff nurse:

It is our policy in public health work to include the husband in our plan for a happy, healthful pregnancy. This is to enable him to understand the physical and mental changes during pregnancy in order that he may contribute to the well-being of his wife and baby. Interest in the coming child may take a creative outlet. One enterprising young father gathered together some laths and boards, tricycle wheels, curtain rods and paint, and proceeded to create a crib.

When the carpentering was finished the crib was painted a delicate shade of pink and a rose transfer design from the "Five and Ten" placed on both ends. The advantages of such a crib are—

1. It is easily wheeled about the house and can be made the right height for the mother
2. The slats give ample circulation of air and yet protect against a direct draught
3. It is attractive as well as useful
4. It is practical and inexpensive (total cost under $2.00)
5. Most important of all it furnishes a creative outlet for an expectant father.

Materials needed:

laths
boards
4 tricycle wheels
2 curtain rods
2 handles from a laundry basket
paint.

The second suggestion comes from the Visiting Nurse Association in Ravenna, Ohio. The clerk in the office devised this crib made from orange crates. It cost not more than fifty cents and will serve a baby for six to eight months, after which it can be used as a play pen or cupboard. Ruth E. Tuttle states:

Materials needed:

5 orange crates (2 for 5 cents)	$ .12½
2 small cans pink paint	.20
2 large sugar sacks (for side curtains and mattress)	.08½
½ yard oilcloth	.10

Corn husks saved from roasting ears were shredded and used to fill the mattress.

Place two crates on their sides, backs fastened together and ends and edges painted, to serve as a foundation on which to place the bed.

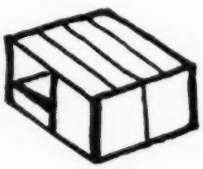
Remove sides from two crates, leaving end boards and bottom strips. Fasten together side by side with strips from the fifth crate and nail the sides back in position making a box higher at each end than on the sides, with double strips over the bottom. Paint.

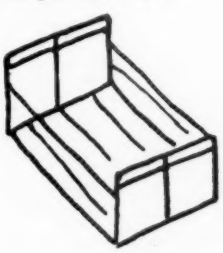
Nail beneath the foundation crates the four heavy wooden squares that were partitions in the crates. The fifth square can be used to make a shelf for toilet articles, etc., in one section of these crates (see picture).

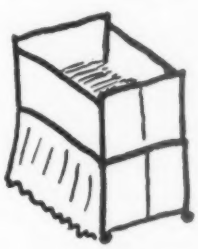
Make mattress of sugar sacks, fill with corn husks, cover with oilcloth.

Line inside of box with paper, old muslin or heavy cardboard.

When finished this bed was 25 inches high, 27 inches long, 23 inches wide. Netting can be arranged over this bed, and it can be put on casters.







Nurse-of-the-Month

MARIE E. THOMAS

Georgia

Miss Thomas is a native Georgian. She is a graduate of the Grady Memorial Hospital School of Nursing, where she had considerable experience in the out-door clinics. After some time spent in field work with the Phi Mu Healthmobile of the State of Georgia and with one of the outstanding rural Health Units, she became an itinerant nurse for the Division of Child Hygiene. In 1929, she began her work with the Jenkins County Health Unit, about four months after its establishment, and in July 1934, became District Supervisor of Field Nurses for the southeast sector of Georgia. She describes her work in Jenkins County.

When the Health Unit was established in Jenkins County, 1929, the public health picture was that of a section having the highest malaria mortality in Georgia. More than 90% of the people were suffering from the disease to some extent and at least 30% of the white school children were infected with hookworm. The former condition was due to inadequate drainage of quiet streams and grassy ponds, where anopholes mosquitoes breed. The latter problem was due to poor sanitation.

This is one of the best farming areas in Georgia along the banks of the Ogeechee River, famous for its shad. The outstanding citizens had been endeavoring to attract more business, but on every hand were told, "I am afraid to locate there on account of the prevalence of malaria."

One of the first attempts of the Health Unit was an extensive educational campaign on the cause, cure and prevention of malaria. People were taught how to take the standard treatment, effective methods of screening and the necessity of good drainage. Formerly, most of the people had used quinine only until the fever and chills had ceased.

As soon as school opened in the fall, students were taught about the cause and prevention of the disease. Each school wrote and put on a play stressing these facts.

A hookworm survey was made. The next problem was how to get these cases treated. A remedy used several years prior to this time had been rather severe and many adults recalled the temporary discomfort. As many as were willing were treated at the school under the supervision of the Health Commissioner and nurse. Later the nurse visited in the homes and was able to get many others interested in treatment.

After handling these two situations as well as possible with a first effort, the nurse's work was outlined on a rather intensive scale, consisting chiefly of follow-up work among school children, communicable disease control, maternity, infancy, and preschool work. Home hygiene classes were organized for adults, and girls were given instruction in child care.

The greater part of the population

outside of Millen, the county seat, are tenants, share-croppers, and day laborers with meager education and very little knowledge regarding correct food habits. About eighty per cent of the rural population are Negroes. To be of service to the entire county, it was necessary to give special consideration to those living in the country, so the nurse spent a great deal of time in the homes, chatting with parents about commonplace things and incidentally getting across a few lessons about the family's health. Special consideration was given to the welfare of preschool children. The nurse became a rather welcome visitor in secluded districts where women seldom get away from home. This personal contact has resulted in a better understanding and has been the means of introducing many ideas about the improvement of home conditions.

Sanitary toilets have been installed in all white rural schools and efforts are being made through F.E.R.A. projects to improve conditions on the farms. During the regime of the C.W.A., Millen passed an ordinance that all unsatisfactory toilets be reconditioned or rebuilt, with a result that 192 were constructed. All the better homes are equipped with modern conveniences. Approximately sixty-six miles of ditches have been cut to drain eighty-one ponds and marshes. Some of these ponds covered several hundred acres.

Annually, the white consolidated schools enter in a competitive way into a plan for emphasizing health lessons. Possibly the most interesting event of this sort was a nutrition project. Three students in each community fed groups of young chickens on diets outlined by the nurse with very striking results. On an appointed day, the students brought to the school the specimen from their group which showed the most difference at the end of the six weeks period. There were some vivid contrasts in the results of right and wrong care. Following this demonstration, there was a marked drop in the number of underweight children in rural schools.

Our infants and preschool children have the privilege of being examined annually by the Health Commissioner. In addition to this, the nurse, as far as possible, visits infants three times during their first year.

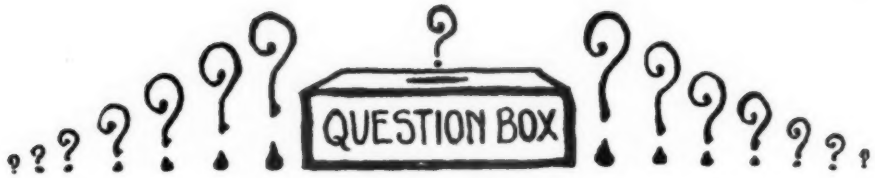
There are about twenty certified midwives in the county, all of whom are Negroes. These women attended last year approximately seventy-one per cent of all live births. Since the middle of 1932 there has been a considerable increase in the number of white confinement cases cared for by midwives, because the family income was much curtailed. We endeavor to get all midwife cases to attend the weekly clinics. Recently group meetings for instruction of expectant mothers and mothers with young children have been held in two rural districts. Midwives attend classes on the first Saturday of each month; their equipment is inspected quarterly.

The State of Georgia has a mobile chest clinic, which visits Jenkins County twice yearly. It is the nurse's duty to locate suspects and contacts, trying to interest them in examination. She organizes the clinics and does the follow-up work among the cases. Before the coming of the first mobile clinic into the county, it had been considered that tuberculosis was very rare in the community. Malaria so obscured illness that diagnosis was difficult. Then, too, the X-ray was not being used as a diagnostic aid; neither were children being tuberculin tested; 502 cases have been examined, 79 of which were positive.

Malaria caused 30 deaths during 1930; last year there were only four deaths from this cause. There was no case of diphtheria, typhoid fever, or smallpox in the county during 1933.

Our population is something above 12,000 with 3,700 children of school age. It takes careful planning to put over the diversified program, but after several years, it is comparatively easy to handle the situation.

There are enough thrills to make up for the disappointments and the biggest remuneration is the growing interest of the majority of the people.



QUESTIONS ON COST OF VISIT

During the summer and fall, several questions relating to the cost of visit were sent to the N.O.P.H.N. and referred to the Service Evaluation Committee. At the meeting of this committee in October the following answers were given:

QUESTION:

Is a clerical worker essential in a one-nurse agency?

ANSWER:

Any arrangement that frees the nurse's time for fie'd service is advantageous and clerical service is usually one of the responsibilities that can be carried either by a volunteer or a part-time clerk. *If such an arrangement does release the nurse for more service in the field,* it would be a legitimate charge to the cost of making visits.

QUESTION:

Does the N.O.P.H.N. Service Evaluation Committee consider an office or desk space and a telephone essential to a one-nurse service?

ANSWER:

Yes. An office or desk space separate from the nurse's living quarters is considered essential, also a telephone, though this may be shared. The important thing is to have a place where supplies and records may be kept and regular office hours and private interviews held.

QUESTION:

In a one-nurse agency is rent chargeable to the cost of the visit?

ANSWER:

Yes (see preceding answer). If donated, a charge in proportion to local rentals for an office or desk space may be included. Rent for space used for activities not chargeable to the making of visits, however, may not be included. The donated rental charge should not exceed the cost of space actually necessary for conducting the visiting activities of the agency. This of course applies to agencies of every size.

QUESTION:

If board and room are supplied to the nurse by the nursing agency, may these be charged to the cost of the visit?

ANSWER:

When board and room are given the nurse in lieu of part of the salary, they are chargeable to salary and thus chargeable to the cost of the visit. The present trend is away from this arrangement. When offered in addition to salary, they are not chargeable.

QUESTION:

Is it permissible to charge the insurance companies on the basis of the actual cost of the nursing service and the community on the basis of what you think they can pay?

ANSWER:

Permissible, but unwise. The charge for service should always be based on the actual cost of service. The insurance companies will pay for visits to policyholders to whom certain types of service are rendered, and the cost per visit for these special services may or may not be the same as the cost per visit for all types of service being offered by the agency to the community. A few cents difference seems negligible, but whether the cost of your general community service is greatly in excess or much less than the charge to insurance companies, the community should know the cost of what it is receiving and be asked to meet it so far as possible. It is better to state the cost frankly, even though it be high, than to mislead contributors and patients and arrive some day at a fatal day of reckoning.

QUESTION:

May we charge to the cost of a visit the fees of a lawyer who has given his service in a matter relating to our nursing service?

ANSWER:

The Service Evaluation Committee has already gone on record as stating that the services rendered as board members and advisory committees are not to be charged to the cost of making visits, these being regarded as the discharge of their duties as officers of the association and not as volunteers. This would include advisory legal service. However, if such service is not available without the payment of a fee, such fees are chargeable to the cost of visit.

QUESTION:

Are public health nursing agencies restoring cuts and salary schedules now?

ANSWER:

Yes, both public and private agencies are making this a goal in 1935.

QUESTION:

Is it permissible to charge unemployment insurance required by state law to the cost of the nursing visit?

ANSWER:

Yes.

B. C. G. VACCINE

QUESTION:

What is the status of B. C. G. vaccine at the present time, how safe is it, and what results are being obtained from its use?

ANSWER:

B. C. G. (Bacillus Calmette Guerin) vaccine is a living culture of tubercle bacilli. Originally, when this was inocu'ated into animals, it proved virulent; that is, it would cause progressive and fatal tuberculosis. However, by special treatment, Calmette eventually was able to attenuate the strain until it no longer caused disease but, when introduced into animals actually seemed to confer a measure of immunity against later infections with fully virulent germs. Subsequently, thousands of children in Europe and, more recently hundreds in this country were vaccinated. Originally the vaccine, mixed in milk, was given by mouth to infants during the first ten days of life. Now it is usually given by subcutaneous injection to infants who previously have escaped tuberculous infections and therefore, do not react to the tuberculin test. Some adults also have been vaccinated. They are then guarded from contact with sources of infection for a month or more during which the immunizing powers of the vaccine are assumed to become effective. Many of those vaccinated then react to the tuberculin test. This positive test indicates that infection has occurred and is assumed by many to indicate that some degree of protection (relative immunity) against subsequent infections has been acquired. Whether or not this latter gain is adequate or significant depends on many factors and is the crux of the question. When a person becomes tuberculin positive from the natural infection which most of us contract, his tissues usually retain this reacting capacity during the rest of his life. In the case of B. C. G., however, this tissue sensitiveness to tuberculin disappears in a few years.

Concerning both the degree and the duration of protection conferred by B. C. G., there has been a good deal of dispute, and the early claims were undoubtedly too optimistic. Several years ago more moderate statistics were assembled by Calmette to show that, when exposed to an environment contaminated with tubercle bacilli, vaccinated children had a death rate of only 3.4 per cent as compared with 15.9 per cent for the unvaccinated. In a more limited but carefully planned and controlled study in New York City, Dr. William H. Park and his associates report a 3 per cent mortality from tuberculosis among unvaccinated children and no deaths from this cause among the vaccinated. In the beginning it was claimed not only that vaccinated infants did not die so often from tuberculosis but also that they were much less likely to succumb to other maladies. This idea, never very reasonable, has since been abandoned.

Grave doubts have been expressed concerning the safety of the vaccine. Theoretically, it is possible that artificially attenuated living tubercle bacilli, introduced into the body, may live there indefinitely and eventually—even after many years—regain much or all of their original virulence. If so, the hazard of developing tuberculosis might be greatly increased rather than minimized. To date no evidence has appeared to indicate that this occurs or is likely to occur from B. C. G. inoculations in human beings, but the final answer must await the lapse of much more time.

There is still a healthy skepticism about the real value of B. C. G. It is generally agreed that the safest and surest way to protect children from tuberculous infection is to protect them from contact with tuberculous people, particularly in the home, and most students of the disease feel that living vaccines should be used only when this better protection cannot be effected. Even the partisans of B. C. G. cannot yet say how long its protective effects will last. Some opponents believe that only killed vaccines, if any, should be used for human beings, arguing that these are equally, if only feebly, effective and devoid of possible harm.

J. BURNS AMBERSON, Jr., M.D.
New York, N. Y.

BOARD MEMBERS PAGE

Edited by KATHARINE BIGGS MCKINNEY

THE GUIDE-POST

What articles shall I, as a board member, read in this number of PUBLIC HEALTH NURSING? To give me a wider view of our community problem, the editorial on Adequate Maternity Service (page 633), the article by Mrs. Carpenter on "An Advisory Committee for Official Agencies" (page 647), (Have we such a committee in our town?); the tribute to and from a board member on pages 662 and 663, and if I am concerned with the financial status of our service, I must not miss page 652, where the new and time-saving method of arriving at the cost of visit is described. Then I will relax a little and read Dr. Clarke's colorful description of Mora County in New Mexico (page 636), jump to Utah and go out with one of the new relief nurses on a hair-raising experience there (page 665), jump again and read "Among the Fields" (page 673) in the state of Washington. If I still had time I'd read "A Parent Education Program in a Health Department" (page 643), "Emergency Nursery Schools" (page 667), and "Maternal Milk Collection" (page 649), to learn of three challenging plans of a quite unusual sort being carried out in Florida, Virginia, and Massachusetts.

NEW RURAL FOLDER ANNOUNCED

A folder, for sale ($2.00) or for rent (postage), is in preparation in the N.O.P.H.N. office. It will contain material on the organization, use, and function of lay advisory committees in *rural* public health nursing services, also references to already published (N.O.P.H.N.) material on this subject and samples of leaflets, programs, volunteer duties, etc., etc., now in use in various states. (All state departments that have contributed their material to the N.O.P.H.N. to make up this folder will receive a free copy for their permanent files). Any rural group organizing for the first time, wishing to get new ideas, to revise their programs, or to reorganize will find this folder valuable.

It will help the office to know how many folders to prepare if you will send in your order for this folder now, *if you intend to buy it;* if you plan to rent it, it is unnecessary to notify us.

Free reprints of the study project—A Manual of Information for Board Members (October PUBLIC HEALTH NURSING) are now available; also *Volunteers—An Asset or a Liability*, single copies free to N.O.P.H.N. members, to others 10 cents.

The N.O.P.H.N. has on hand for free distribution a series of quotations and statements giving evidence to the value and need of public health nursing service at the present time. These can be used effectively for local publicity. Send for your copy.

MISS DAVIS' ITINERARY

Miss Davis, our executive secretary, will have visited in November: St. Petersburg, Fort Myers, Orlando, Tampa, Jacksonville, and Marianna, Florida, to meet with boards and committees of public health nursing organizations and groups concerned with the program of the Emergency Relief nurses. These visits were at the request of the Florida State Department of Health. Future plans include:

Institute for lay groups in Kentucky

Possible institute for lay groups in Colorado

Conference with professionals, board members and volunteers under the auspices of the Council of Social Agencies in Buffalo, N. Y.

FOOD FOR THE BODY AND MIND

Dinner meetings, either as annual meetings or as a "wind-up" to fund-raising efforts, are becoming increasingly popular and successful among public health nursing groups. The Moorestown (N. J.) Visiting Nurse Association reports a dinner meeting at which 307 sat down and 50 more arrived later. The Visiting Nurse Association of Salt Lake City, Utah, invited the public to its annual meeting on colored correspondence cards with a Hallowe'en symbol in the corner. The invitation read:

Vital is the message here presented:
enture forth, October thirty-first;
N. A. will celebrate its birthday
erily, all care will be dispersed.

Now's the time to make your reservation,
ominal the cost for such a meal.
otice—we'll be eating at six-thirty—
ever was a night with such appeal.

Advertise this banquet to the public,
nnually we dine and celebrate.
im to make this party most outstanding.
nd don't forget the time and place and date.

Time: 6:30 P.M. Reservation Until Noon—31st
Place: Chamber of Commerce Visiting Nurse Ass'n
Date: October 31, 1934 85c Per Plate Wasatch 9066

If you are tired of the usual annual meeting, why not try this? The "business" part of the meeting is kept at a minimum (printed reports may be used as place cards if desired) and the highlights of the year given in as interesting and dramatic a way as possible, after coffee is served. The whole meeting should not last more than two hours and a half including the meal.

The Social Work Publicity Council is carrying on a case story review by prominent authors and publishing a series of selected stories with comments in its bulletin. The Council will be glad to receive public health nursing case stories. Address 130 East 22d Street, New York, N. Y.

SALARY CUTS

Word has been received by the N.O.P.H.N. from several public health nursing groups, both public and private, that staff salary cuts and schedules are being restored, if not wholly, in part. Inasmuch as payment from relief funds for inexperienced workers has in some instances exceeded the curtailed salaries of the regular staff workers, and also as costs of living are rising, this seems an essential move if professional standards of work are to be maintained. It is also reëmphasized by the N.O.P.H.N. Committee on Adjustments, that the salary paid nurses engaged in professional work on relief projects should be comparable to the usual remuneration paid graduate nurses in the community by adjusting the time of the working day or week. For example, in a community paying graduate nurses five dollars a day for eight hours of work, a relief nurse on $15 a week would work three days for eight hours, depending on the needs of the service and the most efficient arrangement of her program.

SCHOOL  HEALTH

THE MODERN ELSIE SERIES, NO. III

MISS CARLING STEPS OUT

"Oh, Miss Carling!" The sixth grade teacher caught up to the nurse as she walked down the corridor. "I'm rather worried about Hester Riley. She looks so pale and thin and acts so listless and doesn't seem to take the interest in her work that she did earlier in the fall. Do you suppose there could be something wrong with her?"

"I wonder," Miss Carling replied with a note of concern in her voice. She remembered Hester from last year, an appealing youngster with a shy smile and wistful hazel eyes. "Let's see, your grade doesn't get examined this year, does it, but we might have Dr. Landis look her over some morning. I'll tell you, Miss Hill, I have to make a home visit there soon to see about Tom getting his teeth fixed and I might check up on Hester at the same time. Tom said his father hadn't been working much lately, so I expect they're going to need some help."

"I wish you would, Miss Carling; I think something ought to be done about it."

The next afternoon with some leaflets on dental care and nutrition tucked in her bag Miss Carling called at the Riley home, a small, unattractive house in a rather run-down section of the town. The place looked shabby, the front step was broken down and the house badly needed a coat of paint. Mrs. Riley received her politely if not cordially and invited her into a much-disordered front room, in which the only cheerful spot was a shelf of geraniums blooming brightly in the window. Looking into the kitchen beyond, Miss Carling could see a two-year-old toddling around, a basket containing a week's wash, as yet unironed, on the floor, and the remains of the noon meal on the kitchen table.

A remark or two about how nice her geraniums looked brought a pleased look to Mrs. Riley's face and made conversation easier.

"Mrs. Riley, I've come to see about Tom's teeth. You know I sent a note home to you after he was examined in school saying that he had some bad cavities that needed attention. Have you been able to do anything about it?"

"No, I haven't. You know how it is, nurse, my husband is only working two or three days a week now, sometimes not that much, and it's all we can do to get along and buy food and clothes for the children. Tom needs a new pair of shoes right now, and where they're coming from, I declare I don't know!"

"Perhaps I could help you out there, Mrs. Riley. We do have a supply of clothes at school that we can give out. If you'll tell Tom to stop in my office tomorrow I'll give him a pair of shoes. Perhaps I can get some milk for you, too, from the fund that we have."

"Thank you, nurse, that would be a great help."

"Now, about his teeth, have you heard about the plan the Red Cross has?"

Mrs. Riley hadn't, so Miss Carling explained how the Red Cross had set aside a small loan fund to be used in getting the school children's defects corrected. All the dentists in town had volunteered to give one or two hours a week to the children referred by the school nurse and this fund helped to pay for the materials and a small reimbursement for the work done.

"Do you suppose if we could get Tom's teeth fixed this way your husband could pay a little bit each week, even if it's just fifteen cents or a quarter?"

Mrs. Riley was dubious but thought it might be worth trying and said she would speak to her husband.

"Mrs. Riley, it seems to me Hester has been looking rather thin lately. Is she eating all right?"

"Well, she's sort of picky about her food—her appetite doesn't seem to be so good. I guess maybe she stays up too late evenings, too; I can't seem to get her to bed the way I used to."

Upon pursuing the subject further Miss Carling found out, as she had suspected, that what money was being spent for food went for the most part for starches and meat. Quickly weighing in her mind two alternatives—to give up the other visits she had planned for the afternoon and spend more time with Mrs. Riley, or to make another visit to her later on—she decided to make hay while the sun shone and took the literature out of her bag. Soon she and Mrs. Riley were deep in the outline telling what foods to buy on a limited income, and when they were through, a rough schedule had been made for the next week's menu, with Mrs. Riley still uncertain but willing to make the attempt.

"And I'll ask Hester to come to my office at school, Mrs. Riley, and she can weigh herself and we can talk over her meals and bed time. I'd like to have you come to see my office and some of the things we're doing. I think you'd be interested."

She departed feeling with satisfaction that that was a job well done.

The next morning after the first rush was over, Miss Carling took out her records for Tom and Hester Riley. She wrote up her visit of the day before and jotted down some of the things she wanted to do in that family—"See the Red Cross about Tom's teeth"—"Give Tom a pair of shoes and see about sending in some milk"—"See the membership chairman of the P.-T.A. to get her to invite Mrs. Riley to their next meeting"—"Make another visit soon to buck up Mrs. Riley, check on the diet, and find out more about the preschooler."

"Now," said Miss Carling to herself, as she heard the bell ring for recess, "I'll go talk to Miss Hill and tell her about my visit yesterday."

One morning a week later Miss Carling's telephone rang. It was the case worker from the Family Welfare Society.

"Miss Carling, I was very much surprised when I called on the Riley family yesterday to see that you had given Tom a pair of shoes. Mrs. Riley said that you were going to send them some milk, too. I'm rather sorry you did that, Miss Carling. We've been working with that family for over a year now, and they should be able to get along on what Mr. Riley is making plus the help that we give. Mrs. Riley is not a very good manager, but she is doing better than she did. I'm glad that you talked over the diet with her, as I have been emphasizing that, and your speaking about it too should make more of an impression on her. But I really did want them to try to get along without any additional help. I don't suppose she said anything about my calling on them, but, Miss Carling, did you clear them with the Confidential Exchange?"

"No, I didn't, Miss Dunlap, and I'm so sorry, I should have done that." Miss Carling was most apologetic. "I don't know why, but I was in such a hurry and felt so sorry for them when I got there that I forgot all about it. I certainly will be more careful another time."

Miss Carling hung up ruefully.

"Wouldn't you know it—just when I thought I had done an especially good job with that family, to find that I'd gone about it all wrong! If only I'd taken a little more time in thinking and planning about it, I'd have saved all this trouble. Well, maybe some day I'll learn!"

EDITED BY
DOROTHY J. CARTER

NURSING SCHOOLS—TODAY AND TOMORROW

The Final Report of the Committee on the Grading of Nursing Schools. Available from the National League of Nursing Education, New York. Price, $2.00.

For eight years the Committee on the Grading of Nursing Schools has been at work and no nurse who is interested in the future of nursing needs to be told about the fact-finding studies it has been conducting, for the schools of nursing have been active participators in every study, and the findings have been broadcast in a steady stream of publications, magazine articles, and in Dr. Burgess' book, "Nurses, Patients, and Pocketbooks."

Now comes the final report of the Committee—"Nursing Schools Today and Tomorrow",—an exciting climax to an undertaking which has been marked throughout by its courageous facing of facts. The report, far from being a tedious review of data already published, gives a broad interpretation of the significance of these studies taken as a whole. There is no pussyfooting in these chapters. The Committee has not let us down with fair words. It has neither whitewashed disagreeable truths nor distorted the true picture of the situation by playing them up in high lights while ignoring that which is good. Even so, the chapter "What Most Nursing Schools Are Like" is very unpalatable reading.

The report does not stop with interpretation, but goes on to state in unequivocal terms what the Committee is convinced we must do now to extricate our profession from the woefully unsatisfactory situation it is now in; unsatisfactory alike to the nurse, the patient, the doctor, and the community. In the chapter "The Essentials for a Basic Professional School", the Committee does not content itself with indulging in day dreams of remote ideals but sets forth a definite goal in tangible terms for the school of tomorrow. After this considerable achievement, it might have side-stepped the question of what to do with the schools of today. Not at all. It wrote the chapter, "Certain Conditions Which Should Not Be Tolerated in Schools of Nursing". And now we know what we must do.

We have mentioned only three chapters out of eleven, but these three are enough, perhaps, both to indicate the fearless and sane character of the book and to suggest that the Committee has made good in fulfilling our expectations.

Public health nursing can only go forward on the foundations laid down by schools of nursing. Every nurse who cares about the future of public health nursing has a vital interest in the fundamental education of the nurse. The report of the Committee is very much our concern and should be "read, marked, learned, and inwardly digested" by every one of us.

ELIZABETH G. FOX.

HEALTHY BABIES ARE HAPPY BABIES

Josephine H. Kenyon, M.D. Little, Brown, and Company, Boston. Price, $1.50.

Everything of importance to the baby seems to be included in this newest book on baby care, and yet one has the feeling that there is not a single detail too many. All that the mother needs to know regarding the care of her baby from the time of his birth through his third year has been anticipated and clearly explained.

The first chapter, "Before the Baby Comes", has information for the husband and wife who desire to have a baby. Definite instructions also are given for the prospective mother.

From birth on there is a description of the progress of the baby, including his physical growth and his achieve-

ments, week by week and month by month. With each stage of progress information is given on the needs of growth, including health examination and immunization, additions to the diet, the formation of proper habits, exercises, self-help clothing, and the selection of toys. Interwoven with the consideration of the physical needs of the baby there is much of child psychology. The mother is advised about her own health also, and suggestions are given on diet, exercise and general care from delivery through the involution and nursing periods.

All through the book labor-saving methods and devices are described. The knowledge and understanding of conditions and situations, and the practical suggestions offered should tend to make happy parents as well as happy babies. The author has proved that although there were many books on baby care there was still much left to be said on this subject.

CLARA E. HAYES, M.D.

CHILDREN OF THE NEW DAY

By Katherine Glover and Evelyn Dewey. D. Appleton-Century Company, New York. Price $2.25.

Unfortunate is the reviewer who finds himself caught up in verbless sentences and word usage lacking harmony with educational standards. Constructive criticism is put to a test when one reads that Socrates uttered the challenge, "Know thyself," and that Columbus "set sail to find a new eastward passage to India." One is annoyed by a mood not sufficiently temperate to avoid exaggerations such as "We know today that neglected handicaps breed anti-social beings, foster a psychology that leads to irresponsibility and lawlessness." Bewilderment follows such wishful writing as "We refrain from giving children toy soldiers and cannon to play with"; and the handicapped cared for and educated "often give back to society a hundredfold more than many normally endowed children." An unscientific dogmatism in the description of causes and results bids the reviewer to be careful in his critical judgments.

The purpose of the volume is to present many of the trends and to interpret some of the thoughts and facts brought together by the experts of the Conference Committees who served on President Hoover's White House Conference on Child Health and Protection, and to discuss some data derived from President Hoover's Commission on Social Trends. This purpose has been adequately realized. The authors, however, have not limited themselves to these data but have carefully thought out a large variety of solutions for the difficulties set forth by the conferees. The mode of presentation as a whole is more designed to indicate a plan of social action than to afford definite familial assistance in solving individual problems connected with child development. As a textbook for parents' groups the book should be exceedingly useful. Nurses interested in pediatrics, public health, and social service will derive pleasure and satisfaction in dwelling upon the points of discussion presented in the form of well-selected quotations which accompany each chapter.

The basic doctrine of the Children's Charter still maintains its vitality and inspirational value. Its provisions summarize the content and goal of the volume. The authors find their greatest educational values in life experiences, which is rational and sound doctrine. Their stress upon the use of all knowledge for the purpose of prevention rather than in the interest of cure is in harmony with current ideas of modern medicine and public health nursing. The book ends on a high sounding note of the return of the spiritual motive to life, with spiritual activity interpreted through works rather than words. Possibly the children of the new day will realize the promise of the new day, but when will the new day dawn? There is a long span of time between the ought-to-be and the is.

IRA S. WILE, M.D.

"From This Hill Look Down" by Elliott Merrick (Stephen Daye Press, Brattleboro, Vt., $2.00), a series of sketches from Vermont, is redolent of the Vermont countryside and of interest

to our readers because several chapters tell of the work of a public health nurse in the C.W.A. program.

RECENT BOOKS ON MATERNITY CARE

MATERNAL MORTALITY IN NEW YORK CITY. The Commonwealth Fund, New York. $2.00.

MATERNAL MORTALITY AND MORBIDITY. J. M. Munro Kerr, M.D. William Wood & Company, Baltimore. $8.25. A comprehensive study of this problem in Great Britain.

MIDWIFERY FOR NURSES. Henry Russell Andrews and Victor Jack (London). Seventh edition revised. William Wood & Company, Baltimore. $2.50.

NURSES' HANDBOOK OF OBSTETRICS. Louise Zabriskie, R.N. Fourth edition, J. B. Lippincott, Philadelphia. $3.00.

THE PROSPECTIVE MOTHER: A Handbook for Women during Pregnancy. J. M. Slemons. Third edition. Appleton-Century Company, New York. $2.00.

Maternal Mortality in Fifteen States, a report of the Children's Bureau study, adds convincing evidence to the already existing material of such conditions, as lack of prenatal care, injudicious obstetrics, operative procedure, puerperal septicemia, to mention the most important. Recommendations for each situation are made by the Advisory Committee. 20 cents from the Superintendent of Documents, Washington, D. C.

A Nutrition Outline and Teaching Outline, developed for use in health centers and clinics, has just been published by the Philadelphia Child Health Society, 311 South Juniper Street, Philadelphia, Pa. (price $1.00). Any one planning to teach nutrition in relation to health in any age, with a regard, too, for limited budgets, will find these outlines, questions and complete references indispensable. The outlines are accompanied by charts, tables, recipes and generous suggestions for illustrative material.

A timely booklet entitled *Volunteer Values* has recently been issued by the Family Welfare Association of America (130 East 22d Street, New York, 30 cents). The material has been compiled by Ruth M. Dodd mainly from articles that have appeared in *The Family* and is grouped under four headings:

I. The Unique Contribution of the Volunteer
II. Some Ways of Recruiting Volunteers
III. Ways in Which the Volunteer May Serve
IV. Orienting the Volunteer

A more advanced and elaborate presentation of nutrition in textbook form, comes to us from Riverside Press—"Nutrition" by Margaret S. Chaney, Ph.D. and Margaret Ahlborn, M.S. (Houghton, Mifflin Company, 2 Park Street, Boston, price $3.00). This textbook is suitable for college and normal school use and will serve as a basic reference book for staff nurses. Special chapters are devoted to nutrition during pregnancy and lactation, and during the baby's first year and childhood. Diet in disease is not touched on except as deficiency diets cause or are related to diseased conditions.

FOR MOTHERS' CLASSES

Outlines of a series of talks on prenatal care. The Maternity Center Association of Brooklyn, 117 South Oxford St., Brooklyn, N. Y. 35 cents a set.

Lessons for Expectant Mothers (Revised). Cleveland Child Health Association, 1900 Euclid Avenue, Cleveland, Ohio. 10 cents a set.

An unusually attractive set of posters—attractive in design, color and subject—has been prepared by the University of Texas, Division of Extension, Nutrition and Health Education Bureau, Austin, Texas, and sells for 55 cents a set (8 posters). They illustrate the "rules of the health game" and would be suitable for conference, clinic and school use.

FROM CURRENT PERIODICALS

What I would tell lay audiences regarding prenatal care. Illinois Medical Journal (Oak Park), March, 1934.

Mental health of the expectant mother. A radio talk. By Dorothy E. Hall. Mental Health Bulletin. Illinois Society for Mental Hygiene (Chicago), April, 1934.

Prenatal care in private and clinic practice. G. D. Royston, M.D. American Journal of Obstetrics and Gynecology (St. Louis), March, 1934.

Obstetrics versus midwifery. J. B. DeLee, M.D. Journal of the American Medical Association (Chicago), August 4, 1934.

As a part of the drive for better health conditions among the Indians, a "trachoma school" accommodating approximately three hundred children has been opened on the Fort Apache Reservation in Arizona, under the auspices of the Indian Service. Indians have long been peculiarly susceptible to this dreaded eye ailment. In some tribes it afflicts as many as forty per cent of the entire population. Because many of these Indian sufferers live at great distances from health centers, and because funds for educational work have been lacking, it has been possible to do very little to check the spread of this infectious malady. By the establishment of the school, a large number of children can be given intensive treatment and close observation. The fact that the Indians themselves voted for it and subscribed $20,000 of their tribal funds toward the upkeep is one of the most hopeful features of the project.

✣

The following officers were elected by the Public Health Nursing Section of the Indiana State Nurses' Association at the annual meeting in Fort Wayne: Beatrice Short, Indianapolis, *Chairman;* Mathilda Lobline, Seymour, *Vice-Chairman;* Genevieve Shaw, Logansport, *Secretary.*

✣

The Annual Conference of the National Society for the Prevention of Blindness will be held in New York City December 6-8. Among the topics that will come up for discussion at the Conference will be: The causes of blindness; sight-saving classes for children with seriously defective vision; prevention of eye accidents; and prevention of prenatal infections which may cause blindness.

✣

The American Social Hygiene Association has found it necessary to withdraw its name as sponsor of the film, "Damaged Lives." This action was taken not because the friends and advisers of the Association have changed their points of view in regard to the value of these films. The correspondence and opinions expressed generally support the judgment that these films have important educational and informational value. But it has apparently proved impossible for the Weldon Pictures Corporation, the owners of the film, with its limited organization and commercial affiliations to control undesirable and unauthorized activities of distributors and exhibitors in the local advertising and showings of the films.

The Association feels that the experiment has been worth while and that the experience gained will possibly pave the way for entirely successful projects in the future.

✣

The national convention of the American Physical Education Association and its Eastern District Society will be held in Pittsburgh, Pa., April 24-27, 1935.

✣

Miss H. Irene Clouser, R.N., Reading, won first prize in the essay contest for nurses in Pennsylvania conducted jointly by the Pennsylvania Tuberculosis Society and the Pennsylvania State Organization for Public Health Nursing. The subject was The Function of the Nurse in the Control of Tuberculosis. Miss Clouser for six years has been a member of the staff of the Reading Tuberculosis Association. Previously she was connected with the Visiting Nurse Association in Reading, following her graduation from the Training School of the Reading Hospital.

✣

Over 2,000 communities in 34 states participated in National Negro Health Week April 1-8, 1934, according to *National Negro Health News.* Thousands of homes were cleaned and painted; lec-

tures and radio talks given; clinics, plays, and pageants held. The Iberville (La.) Parish Training School won the Poster Contest with a poster entitled "The Health Circus."

✣

The National Association of Colored Graduate Nurses is sponsoring a Regional Conference for nurses in Alabama, Mississippi, Louisiana, Texas, Tennessee, Oklahoma, and Florida. This conference will be held in New Orleans from November 30 to December 2. Mrs. Estelle Massey Riddle, chairman of the Association, and Mrs. Eola V. Lyons, chairman of the Educational Committee, are planning to make this conference meet the needs of the nurses in these sections. For further information write to the National Association of Colored Graduate Nurses, 50 West 50th Street, New York.

✣

Sickness insurance of school children, as a supplement to insurance of adults, is required by law in eight of the twenty-five cantons of Switzerland. In seven other cantons such insurance is required only in some communes. In several cantons the insurance law applies only to children attending kindergarten or elementary public schools; in others it applies to all children of certain ages, whether they attend school or not.

Each insured child pays into the insurance fund about 15 to 20 francs annually ($2.80 to $3.80); in case of poverty the payment is made by the commune; in addition the Federal Government and the cantons contribute, together, about half of this amount.

The purpose of the insurance is to provide medical attendance and medicines in case of illness or accident; also when necessary special kinds of treatment, such as ultraviolet ray, X-ray, or orthopedic. Undernourished children and those in need of recuperation or rest are sent to special resorts in the country or in the mountains. Parents or guardians failing to insure their children or wards are subject to penalties.

The number of insured children increased from 25,000 in 1914, when the social insurance law of 1911 went into effect, to 338,000 in 1932.—*Bulletin, United States Children's Bureau.*

APPOINTMENTS

Virginia Elliman, Educational Supervisor, Instructive Visiting Nurse Association, Richmond, Virginia.

Gladyce L. Badger, nursing field representative for New York and New Jersey, American Red Cross.

Ann C. Gring, Nursing Field Representative, American Red Cross, for Massachusetts, Rhode Island and Connecticut.

Gertrude Hosmer, Director of the newly-organized Visiting Nurse Association of Dallas, Texas.

MIDWIFERY STANDARDS

The Sixth Congress of the International Federation of Midwives Associations, London, May, 1934, reports:

"Having heard with deep interest from representatives from Italy, Hungary and Switzerland that in these countries it is the rule that a trained midwife shall assist the doctor in all cases of midwifery undertaken by him, this Sixth Congress of the International Midwives Union, representing organized midwives in twelve countries, is of opinion that a midwife shou'd be engaged for every confinement whether or no a doctor is also engaged. It urges its national organizations to press for this reform in the interests of the mother and the lowering of the maternal mortality rate.

"It is desirable that for midwives there should be one official diploma only, requiring a training of at least three years of study and education in preparation for the threefold task of the care of mothers and young children, the carrying out of social legislation and the teaching of hygiene and mothercraft. The training in the social aspect of their work should be comprehensive and compulsory for all pupil midwives."

Excerpt—Nursing Notes and Midwives' Chronicle (London) July, 1934.

Index photographed at the
beginning for the convenience
of the microfilm user.